## BENEFICIARY DESIGNATION FOR
## SOUTH CENTRAL MN ELECTRICAL WORKERS FAMILY HEALTH PLAN

1. I, ________________________________________ (Please Print Name), hereby designate my death beneficiary or beneficiaries under the Plan, as follows:

   A. **Primary Beneficiary or Beneficiaries**. All of my death benefit shall be paid in equal shares (unless otherwise specified) * to such of the following persons as survive me:

| Name*, Address and Phone Number of Person(s) Designated | Social Security Account Number | Relationship To Me |
|---|---|---|

   B. **Alternative Beneficiary or Beneficiaries**. If none of the persons named in Part A above survives me, all of my death benefit shall be paid in equal shares (unless otherwise specified)* to such of the following persons as survive me:

| Name*, Address and Phone Number of Person(s) Designated | Social Security Account Number | Relationship To Me |
|---|---|---|

**Participant's Signature** _________________________________ **Date**______________

**Participant's Social Security Number**________________________________________

**Street Address**__________________________________________________________

**City, State, Zip Code**_____________________________________________________

**Phone Number**________________________________________

### CONSENT AND ACKNOWLEDGEMENT BY PARTICIPANT'S SPOUSE

I consent to this (and only this) beneficiary designation. My consent is not revocable—I cannot take it back. I know that this beneficiary designation controls payment of the entire death benefit. Because I have consented to this beneficiary designation, I may receive no death benefit at all from the Plan. I understand that the Participant is free to change this beneficiary designation without any further notice to or consent by me. If the Participant changes this beneficiary designation and dies while married to me, however, I will have the right to receive his or her entire death benefit unless I, in a writing witnessed by a notary public, have consented to and acknowledged the effect of the changed beneficiary designation.

Signed before me this ____________ day of

____________________________________

____________________________________
Notary Public

______________________________
Signature of Participant's Spouse

Note: Please deliver this Form to:

South Central MN Electrical Workers
Family Health Plan
c/o Wilson-McShane Corporation
1330 Conway St, Suite 130
St. Paul, MN 55106

The above designation was received on

______________________________

By:____________________________