



PENSION & HEALTH PLANS

## PENSION & INDIVIDUAL ACCOUNT PLANS

# Pension and Individual Account Plans Beneficiary Designation Form

To use this form correctly, first carefully read all the instructions below, then completely fill-in the information requested on the back of this form. Remember to sign and date the form before submitting to the Plan Office.

1	2	3	4	5	6	7	8	9	0	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z
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### Instructions for Completing This Form:

1. Please print characters in CAPITAL LETTERS, as shown above. Use only black or dark blue ink.
2. Complete the "Participant Information" section in full.
3. Complete the "Beneficiary Information" section to designate a Primary beneficiary.
4. If designating multiple beneficiaries, also complete the "Additional Beneficiaries" sections.
5. If neither "Type" box under Additional Beneficiary is selected, 100% of the benefit will be paid to the Primary beneficiary, and any Additional Beneficiary will automatically be treated as a Contingent Beneficiary.
6. If the same "Type" box is selected for multiple beneficiaries, the benefits will be divided equally unless a different benefit percentage is indicated for each beneficiary.
7. A completed form must be signed and dated before it can be accepted by the Plan Office.
8. A form completed online must be printed, signed, and submitted in hard copy to the Plan Office for processing.
9. Submit completed form in a sealed envelope to:

**MPI Pension & Individual Account Plans**  
**P.O. Box 1999**  
**Studio City, CA 91614-0999**

### ***Please Note:***

1. This designation revokes all prior designations.
2. A "Primary" beneficiary is the individual or entity you designate to receive the death benefit.
3. A "Contingent" beneficiary(ies) will only receive a benefit if the Primary beneficiary is already deceased when the Participant dies.
4. If you are married for at least one year on the date of your death, your spouse will automatically be your beneficiary.
5. If you name someone other than your current spouse as beneficiary, the designation will only be operative if your spouse dies or you are divorced.
6. If you name your current spouse and you later divorce, that person will no longer be considered your beneficiary unless you complete a new form after the effective date of your divorce, or if a court order provides that death benefits are payable to your ex-spouse.
7. This form is not valid for designation of Motion Picture Industry Health Plan benefits. You must complete a Health Plan Beneficiary card to designate the recipient(s) of health benefits.
8. New beneficiary forms will not be accepted by the Plan Office after the Participant's date of death.
9. This form may not be applicable after your retirement date. [Upon retirement, you will be required to re-designate your beneficiary(ies) based on the retirement option selected.]

***This form is available for on-screen completion at the Plans' website: [www.mpiphp.org](http://www.mpiphp.org), but must be printed, signed, and submitted in hard copy.***

# Motion Picture Industry Pension and Individual Account Plans - Beneficiary Designation Form

(Please read the instructions on the front before completing this form.)

**Participant Information** (Please use a **BLACK or Dark Blue** pen and print clearly in CAPITAL LETTERS)

Last Name	First Name	MI	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced
Social Security Number	Birth Date (MM/DD/YYYY)	Phone Number	
Street Address	Apt. #		
City	State	ZIP Code	<input type="checkbox"/> Male <input type="checkbox"/> Female

**Beneficiary Information**      **PRIMARY**      Relationship

Last Name	First Name	MI	Benefit %:
Social Security Number	Birth Date (MM/DD/YYYY)	Phone Number	
Street Address	Apt. #		
City	State	ZIP Code	

**Additional Beneficiary**    Type:  Primary  Contingent (Default)      Benefit %:

Last Name	First Name	MI	Benefit %:
Relationship			
Social Security Number	Birth Date (MM/DD/YYYY)	Phone Number	
Street Address	Apt. #		
City	State	ZIP Code	

**Additional Beneficiary**    Type:  Primary  Contingent (Default)      Benefit %:

Last Name	First Name	MI	Benefit %:
Relationship			
Social Security Number	Birth Date (MM/DD/YYYY)	Phone Number	
Street Address	Apt. #		
City	State	ZIP Code	

I hereby designate my new beneficiary(ies) under the Plans. This designation hereby revokes all prior designations.

**Participant's Signature:** \_\_\_\_\_      Date: (MM/DD/YYYY) \_\_\_\_\_

**IMPORTANT:** If the same "Type" box is selected for multiple beneficiaries, the benefits will be divided equally unless a different benefit percentage is indicated for each beneficiary.