

Western States Office and Professional Employees Pension Fund

ENROLLMENT/ BENEFICIARY FORM

New Enrollment Change in Address Change in Beneficiary Change in Name

PARTICIPANT INFORMATION:

Participant's Name:* _____ SSN:* _____

Former Name: _____ Date of Birth: * _____

Address:* _____ Email: _____
Street

_____ Sex:* Male Female
City State Zip Code

Phone No.: _____ Member OPEIU Local: _____

Marital Status:* Married Single, never married Divorced Widowed Other

Spouse's Name: _____ Date of Marriage: _____

* Required to properly value your pension and keep you informed.

BENEFICIARY INFORMATION:

Name of Beneficiary: _____ Relationship: _____

Address: _____ Date of Birth: _____

_____ SSN: _____
City State Zip Code

IMPORTANT: Federal Law requires a married participant to name his or her spouse as the sole beneficiary of pension plan benefits unless the spouse consents in writing (next section) to another primary beneficiary designation. For a married Participant, federal law (ERISA) requires that the Plan's normal form of retirement is a Joint and 50% Survivor Annuity. The Joint and Survivor 50% Annuity provides a reduced lifetime pension, and after your death, a lifetime pension for your surviving spouse equal to one-half of the monthly pension paid to you if your spouse survives you. If you have named a person other than your spouse as your beneficiary, your spouse must complete the spousal consent (next section) on the reverse side of this form. Your spouse's signature must be witnessed by a Notary Public or a Plan Representative.

EMPLOYEE'S SIGNATURE: _____ DATE: _____

SPOUSAL CONSENT FORM

The following must be completed by your spouse if a person other than our spouse is the named beneficiary.

I, _____, swear that I am the legal spouse of the above Plan participant. I hereby consent to my spouse naming the beneficiary listed on the reverse side of this form to receive my spouse's survivor's benefit. If my spouse dies before retirement and before my spouse qualifies for early retirement, I understand by this consent that I cannot unilaterally revoke this designation and that I will not be paid a survivor's benefit.

Spouse's Signature: _____ Date: _____
(Signature must be witnessed by a Notary Public or a Plan Representative)

TO BE COMPLETED BY A NOTARY PUBLIC

State of _____, County of _____

On _____, 2____, before me, a Notary Public of said State, duly commissioned and sworn, personally appeared _____, known to me (or proved to me on the basis of satisfactory evidence of _____) to be the person whose name is subscribed above and acknowledged that the person executed this consent.

Notary Public in and for the said State

Commission Expiration Date

TO BE COMPLETED BY PLAN REPRESENTATIVE

Signature of spouse witnessed this _____ day of _____, 2____ in the presence of: _____
Plan Representative Signature

Form of I.D.

Print Name

THE INFORMATION REQUESTED ON THIS FORM MUST BE COMPLETED AND THEN BE ON FILE WITH THE FUND'S ADMINISTRATOR IN ORDER TO BE VALID. PLEASE RETURN THIS FORM TO:

**WESTERN STATES OFFICE & PROFESSIONAL EMPLOYEES PENSION FUND
PO BOX 4148 PORTLAND, OR 97208**