MICHIGAN ELECTRICAL EMPLOYEES' HEALTH PLAN

BENEFICIARY DESIGNATION FORM
DEATH BENEFIT

PARTICIPANT NAME: _____

MID OR SOCIAL SECURITY NUMBER: _____

The Michigan Electrical Employees' Health Plan (the "Plan") provides for payment of death benefits to an eligible beneficiary. You should use this form to designate a beneficiary or beneficiaries to receive a benefit, if any, payable upon your death. You may change this designation at any time. If you designate more than one Primary Beneficiary, the death benefit will be paid in accordance with the designated percentage indicated below. If no shares are designated, the benefit will paid in equal shares to such surviving Primary Beneficiaries. If no Primary Beneficiary survives you, payment will be made in accordance with the designation of Contingent Beneficiary(ies) or in accordance with the terms of the Plan if there are no eligible Contingent Beneficiary(ies). If your marital status changes, you must complete a new Beneficiary Designation Form.

I, the undersigned, hereby revoke any and all prior death benefit designations or directions to the Plan and hereby direct that any benefits payable pursuant to the terms of the Plan upon my death be paid to the beneficiary or beneficiaries described below.

PRIMARY BENEFICIARY: NAME OF PERSON(S) YOU WANT TO RECEIVE YOUR DEATH BENEFIT
(If you name more than one Primary Beneficiary, they will share equally unless you state otherwise)

NAME (LAST)	(FIRST)	(INITIAL)	BIRTHDATE	MID OR SS #	RELATIONSHIP	SHARE
						0%
STREET ADDRESS		CITY	STATE	ZIP	PHONE #	
NAME (LAST)	(FIRST)	(INITIAL)	BIRTHDATE	MID OR SS #	RELATIONSHIP	SHARE
						0%
STREET ADDRESS		CITY	STATE	ZIP	PHONE #	
NAME (LAST)	(FIRST)	(INITIAL)	BIRTHDATE	MID OR SS #	RELATIONSHIP	SHARE
						0%
STREET ADDRESS		CITY	STATE	ZIP	PHONE #	

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If no Primary Beneficiary(ies) survives me, I designate the following Contingent Beneficiary(ies) to receive my death benefit.

CONTINGENT BENEFICIARY: NAME OF PERSON(S) YOU WANT TO RECEIVE YOUR DEATH BENEFIT
(If you name more than one Contingent Beneficiary, they will share equally unless you state otherwise)

NAME (LAST)	(FIRST)	(INITIAL)	BIRTHDATE	MID OR SS #	RELATIONSHIP	SHARE
						0%
STREET ADDRESS		CITY	STATE	ZIP	PHONE #	
NAME (LAST)	(FIRST)	(INITIAL)	BIRTHDATE	MID OR SS #	RELATIONSHIP	SHARE
						0%
STREET ADDRESS		CITY	STATE	ZIP	PHONE #	
NAME (LAST)	(FIRST)	(INITIAL)	BIRTHDATE	MID OR SS #	RELATIONSHIP	SHARE
						0%
STREET ADDRESS		CITY	STATE	ZIP	PHONE #	

I understand that, in the event of my death, the most recently signed, dated, and witnessed beneficiary form on file with the Plan Office will be used to determine the beneficiary(ies) who will receive my death benefit. I further understand that if none of the beneficiaries designated above are eligible to receive a death benefit (e.g., they pre-decease me), payment shall be made to such beneficiary or beneficiaries pursuant to the terms of the Plan under such circumstances.

I hereby certify that the foregoing statements are to the best of my knowledge and belief true, correct, and complete.

Signatures Required: This designation will not be valid unless signatures and dates below are filled out completely.

_____ _____

Participant Signature **Witness Signature**
(not a named beneficiary)

_____ _____

Date **Date**

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