MICHIGAN LABORERS' PENSION FUND
BENEFICIARY DESINGATION FORM

(To be completed by participant)

PLEASE PRINT

<table>
<tr><td colspan="3">Purpose for Completing Form:
□ New Participant □ Change Beneficiary □ Address Change □ Name Change________
(previous name)</td></tr>
<tr><td colspan="3">NAME OF PARTICIPANT:
Last First MI</td></tr>
<tr><td>SOCIAL SECURITY NUMBER:</td><td colspan="2">PARTICIPANT DATE OF BIRTH:
Month Day Year</td></tr>
<tr><td colspan="3">ADDRESS OF PARTICIPANT:
Street City State ZIP</td></tr>
<tr><td>GENDER
☐ M ☐ F</td><td colspan="2">MARITAL STATUS ☐ Single
☐ Married ☐ Divorced ☐ Widowed</td></tr>
<tr><td>PARTICIPANT PHONE NUMBER:
( )</td><td colspan="2">PARTICIPANT EMAIL ADDRESS:</td></tr>
<tr><td colspan="3">LOCAL UNION NO:</td></tr>
<tr><td colspan="3">BENEFICIARY DESIGNATION FOR UNMARREID PARTICIPANT – I understand that this beneficiary designation cancels any previous designation I may have made. Further, I understand that this designation shall automatically be cancelled if I am or become legally married for one year and my spouse will automatically become my beneficiary. I hereby state that I am NOT married and I hereby designate as my beneficiary/beneficiaries to receive any benefits that may be payable under the Pension Plan in the event of my death the following person(s):</td></tr>
<tr><td>NAME OF BENEFICIARY:</td><td>RELATIONSHIP:</td><td>SOCIAL SECURITY NUMBER:</td></tr>
<tr><td colspan="3">ADDRESS OF BENEFICIARY:</td></tr>
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<tr><td colspan="3">I understand that this beneficiary designation supersedes any previous designation signed prior to the date shown below. NOTE: If you name more than one person, any benefit payable will be paid in equal shares.</td></tr>
<tr><td>DATE OF SIGNATURE</td><td colspan="2">SIGNATURE</td></tr>
</table>

For questions, contact the Administration Office at toll-free 877-MI-LABOR (877-645-2267)

Return completed form to:

Michigan Laborers' Pension Fund
Administration Office, P.O. Box 211133, Eagan MN 55121-2533
or Fax to: (517) 689-6016