



# Participant Beneficiary Designation

**Mark all that apply:**

457(b) Plan       401(a) plan       Defined Benefit Plan  
(if nothing is selected, this form applies to all Plans)

Name: \_\_\_\_\_ Email: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ County/Jurisdiction: \_\_\_\_\_

- If you name more than one primary or contingent beneficiary, the "Percent to Beneficiary" category must equal 100%.
- The "Percent to Beneficiary" can be split up to two decimal points (Example: 33.33%)
- Sign, Witness and date the form certifying the information.
- If more space is needed, an additional sheet may be attached to this form.
- Defined Benefit Plan: The beneficiary (ies) designed on this form relates only to the receipt of a lump sum or balance of period certain benefits payable.

Primary Beneficiary			
Name: _____	SS#: _____	Date of Birth _____	Sex: _____
Address: _____	City: _____	State: _____	Zip: _____
Relationship to Participant: _____		Percent to Beneficiary: _____	

### PLEASE CHECK PRIMARY OR CONTINGENT FOR THE ADDITONAL BENEFICIARIES

<input type="checkbox"/> PRIMARY <input type="checkbox"/> CONTINGENT			
Name: _____	SS#: _____	Date of Birth _____	Sex: _____
Address: _____	City: _____	State: _____	Zip: _____
Relationship to Participant: _____		Percent to Beneficiary: _____	

<input type="checkbox"/> PRIMARY <input type="checkbox"/> CONTINGENT			
Name: _____	SS#: _____	Date of Birth _____	Sex: _____
Address: _____	City: _____	State: _____	Zip: _____
Relationship to Participant: _____		Percent to Beneficiary: _____	

<input type="checkbox"/> PRIMARY <input type="checkbox"/> CONTINGENT			
Name: _____	SS#: _____	Date of Birth _____	Sex: _____
Address: _____	City: _____	State: _____	Zip: _____
Relationship to Participant: _____		Percent to Beneficiary: _____	

**You have the right to revoke or change any beneficiary designation.**

The Trustee will pay all sums payable under the Plan by reason of my death to the primary beneficiary, if they survive me. If no primary beneficiary survives me, then the contingent beneficiary will be paid all sums payable under the Plan by reason of my death. If no named beneficiary survives, my account will be distributed in accords with the Plan document.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Required Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(must not be listed as a beneficiary)