
Your Retirement Plan Designation of Beneficiary Form

PARTICIPANT INFORMATION: (Please print information clearly)

Employee Name: _____

Street: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____

Date of Birth: _____

I hereby revoke any Designation of Beneficiary I may previously have made under the above Plan and designate the following as my Beneficiary(ies) under the Plan:

Primary Beneficiary(ies)

<i>Name</i>	<i>Relationship</i>	<i>Social Security Number</i>	<i>% Share</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Contingent Beneficiary(ies)

<i>Name</i>	<i>Relationship</i>	<i>Social Security Number</i>	<i>% Share</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CURRENT MARITAL STATUS (check one)

- ☐ **I am not married.** I understand that if I become married in the future, this form automatically ceases to apply and I should file a new Designation of Beneficiary.
- ☐ **I am married.** If my spouse is not the only Primary Beneficiary, my spouse has signed the consent on this form. (If consent of your spouse cannot be obtained – e.g., cannot be located or is incapacitated – contact your employer for information about possible alternatives.) I understand that if my marital status changes, this Designation will nevertheless remain in effect until I file a new Designation.

Participant's Signature_____
Date**SPOUSE'S CONSENT**

I hereby approve of, and consent to, the beneficiary designation adopted by my spouse as provided above. I understand that I am entitled to receive a spousal benefit under the Plan unless I consent to a different beneficiary designation. I also understand that the above designation has the effect of causing the death benefit under the Plan to be paid to another beneficiary. I further understand that my spouse may not change the primary beneficiary designation above without first obtaining my written consent.

Name of Spouse_____
Spousal Signature_____
Date

Sworn to, and witnessed by me, this _____ day of _____ (month), _____

Name of Notary Public: _____

Notary Public's Signature: _____

If not notarized, witnessed by: _____

Name of Plan Administrator_____
Plan Administrator's Signature_____
Date**Please return this form to your employer.**