Housing Agency Retirement Trust — Change of Beneficiary Designation Form - #140

Plan Number: 5 9 8 3 6 2

Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Employee Name: _____

Last, First, Middle

I. Beneficiary Instructions - This form revokes any previous designations.

This Beneficiary Designation Form is used to designate the recipient of your retirement account balance, and if applicable your life insurance benefit, payable upon your death.

Section II. A primary beneficiary and a contingent beneficiary may be designated. If the primary beneficiary(ies) predeceases you, the contingent beneficiary(ies) will receive the account balance. If you elect to designate more than two primary and/or more than two contingent beneficiaries, you must attach any additional beneficiary form(s). Please ensure all primary beneficiaries' benefit percentages total 100%. Also, ensure all contingent beneficiaries' benefit percentages total 100%. Please note that a Joint Primary Beneficiary can be the same person named as the contingent beneficiary. If none of my designated beneficiaries are living at the time of my death, or I have not designated a beneficiary, then any distribution of my retirement plan accounts shall be paid in a single sum to my estate. Sign and date the form upon completion.

II. Beneficiary Designation – Retirement Plan

Primary Beneficiary

SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ ____%

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Relationship: _____ ex: (Spouse, Daughter, Son, etc.)

Primary Beneficiary

SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ ____%

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Relationship: _____ ex: (Spouse, Daughter, Son, etc.)

Contingent Beneficiary

SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ ____%

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Relationship: _____ ex: (Spouse, Daughter, Son, etc.)

Contingent Beneficiary

SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ ____%

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Relationship: _____ ex: (Spouse, Daughter, Son, etc.)

III. Beneficiary Designation - Supplemental Death Benefit / Life Insurance (if applicable)

Primary Beneficiary

SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ ____%

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Relationship: _____ ex: (Spouse, Daughter, Son, etc.)

Primary Beneficiary

SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ ____%

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Relationship: _____ ex: (Spouse, Daughter, Son, etc.)

Contingent Beneficiary

SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ ____%

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Relationship: _____ ex: (Spouse, Daughter, Son, etc.)

Contingent Beneficiary

SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ ____%

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Relationship: _____ ex: (Spouse, Daughter, Son, etc.)

IV. I certify that this information is correct.

Signed at (City, State) _____ this the _____ day of _____ , _____

Month *Year*

Housing Authority-Asheville

Name of Employer

Signature of Agency Authorized Official or Notary *(Required)*

Signature of Employee

Notary Public (Signature)

Date

Commission Expires

Please keep a copy for your records and mail original to:

Housing Agency Retirement Trust, c/o ADP Retirement Services, 4801 Olympia Park Plaza Drive, Suite 2000, Louisville, KY 40241
PHONE: 1-800-798-2044, FAX: 1-973-712-7489

DEPT = RKOPSHART
TASK - CHGFORM

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