

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: _____ - _____ - _____ <input style="width: 40px; height: 15px;" type="text"/> % Name: _____ Mailing Address: _____ City: _____ State: _____ Zip: _____ Relationship: _____ ex: (Spouse, Daughter, Son, etc.)	Primary Beneficiary SSN: _____ - _____ - _____ <input style="width: 40px; height: 15px;" type="text"/> % Name: _____ Mailing Address: _____ City: _____ State: _____ Zip: _____ Relationship: _____ ex: (Spouse, Daughter, Son, etc.)
Contingent Beneficiary SSN: _____ - _____ - _____ <input style="width: 40px; height: 15px;" type="text"/> % Name: _____ Mailing Address: _____ City: _____ State: _____ Zip: _____ Relationship: _____ ex: (Spouse, Daughter, Son, etc.)	Contingent Beneficiary SSN: _____ - _____ - _____ <input style="width: 40px; height: 15px;" type="text"/> % 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: _____ - _____ - _____ <input style="width: 40px; height: 15px;" type="text"/> % Name: _____ Mailing Address: _____ City: _____ State: _____ Zip: _____ Relationship: _____ ex: (Spouse, Daughter, Son, etc.)	Primary Beneficiary SSN: _____ - _____ - _____ <input style="width: 40px; height: 15px;" type="text"/> % Name: _____ Mailing Address: _____ City: _____ State: _____ Zip: _____ Relationship: _____ ex: (Spouse, Daughter, Son, etc.)
Contingent Beneficiary SSN: _____ - _____ - _____ <input style="width: 40px; height: 15px;" type="text"/> % Name: _____ Mailing Address: _____ City: _____ State: _____ Zip: _____ Relationship: _____ ex: (Spouse, Daughter, Son, etc.)	Contingent Beneficiary SSN: _____ - _____ - _____ <input style="width: 40px; height: 15px;" type="text"/> % 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** _____

_____ <i>Name of Employer</i>	_____ <i>Signature of Agency Authorized Official or Notary (Required)</i>	_____ <i>Signature of Employee</i>
_____ <i>Notary Public (Signature)</i>	_____ <i>Date</i>	_____ <i>Commission Expires</i>

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**

Revised June 2012