

Beneficiary Designation Form



Fringe Benefits Consortium

| | | | | |
|--------------------------------|--|------------------------|--|---------|
| Employee Instructions | The Beneficiary Designation Form is to be used to establish or change the named beneficiary for your 403(b), 457(b) and 401(a) Retirement Accounts. Please complete all of the steps outlined below. Upon completion, please fax a copy of this form to (800) 597-8206 | | | |
| Employee Information | Participant Name | Social Security Number | Current Date | |
| Beneficiary Designation | Please select and complete one of the options below: | | | |
| | <input type="checkbox"/> Option 1 I am NOT MARRIED and designate the following person(s) to receive any death benefits. I understand that if I marry, this designation becomes void one year after my marriage. | | | |
| | SSN | Name | Relationship | Address |
| | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| | <input type="checkbox"/> Option 2 I am MARRIED and designate my spouse named below to receive ALL death benefits from the Plan. | | | |
| | Spouse: | | | |
| | | Name | _____ | |
| | | SSN | _____ | |
| | | Address | _____ | |
| | | | _____ | |
| | If my spouse is not living, pay death benefits to: | | | |
| | SSN | Name | Relationship | Address |
| | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| | <input type="checkbox"/> Option 3 I am MARRIED and designate the following person(s) to receive death benefits from the Plan (spousal consent required -- see below). | | | |
| | SSN | Name | Relationship | Address |
| | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| Spousal Consent | I consent to this designation which eliminates all or part of the benefits otherwise payable to me from the Plan if my spouse dies. | | | |
| | Spouse's Signature (Required for Option 3) | Date | Notary Public or Plan Administrator (Required for Option 3) | Date |
| | _____ | _____ | _____ | _____ |
| Employee Signature | Employee Signature | Date | | |
| | X | _____ | | |

Upon completion, fax a copy to (800) 597-8206.