

# Participant Beneficiary Form

Mark all that apply:  457 Plan  401(a) Plan  Defined Benefit  
 (if not checked, form applies to all Plans)

PARTICIPANT NAME: \_\_\_\_\_ TEL/EMAIL: \_\_\_\_\_

SOCIAL SECURITY NO.: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

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

Primary Beneficiary	
NAME: _____	<input type="checkbox"/> M <input type="checkbox"/> F SS#: _____ DATE OF BIRTH: _____
ADDRESS: _____	CITY: _____ STATE: _____ ZIP CODE: _____
RELATIONSHIP TO PARTICIPANT: _____	PERCENT TO BENEFICIARY: _____

**PLEASE CHECK PRIMARY OR CONTINGENT FOR THE ADDITIONAL BENEFICIARIES**

PRIMARY <input type="checkbox"/>	CONTINGENT <input type="checkbox"/>
NAME: _____	<input type="checkbox"/> M <input type="checkbox"/> F SS#: _____ DATE OF BIRTH: _____
ADDRESS: _____	CITY: _____ STATE: _____ ZIP CODE: _____
RELATIONSHIP TO PARTICIPANT: _____	PERCENT TO BENEFICIARY: _____

PRIMARY <input type="checkbox"/>	CONTINGENT <input type="checkbox"/>
NAME: _____	<input type="checkbox"/> M <input type="checkbox"/> F SS#: _____ DATE OF BIRTH: _____
ADDRESS: _____	CITY: _____ STATE: _____ ZIP CODE: _____
RELATIONSHIP TO PARTICIPANT: _____	PERCENT TO BENEFICIARY: _____

PRIMARY <input type="checkbox"/>	CONTINGENT <input type="checkbox"/>
NAME: _____	<input type="checkbox"/> M <input type="checkbox"/> F SS#: _____ DATE OF BIRTH: _____
ADDRESS: _____	CITY: _____ STATE: _____ ZIP CODE: _____
RELATIONSHIP TO PARTICIPANT: _____	PERCENT TO BENEFICIARY: _____

PRIMARY <input type="checkbox"/>	CONTINGENT <input type="checkbox"/>
NAME: _____	<input type="checkbox"/> M <input type="checkbox"/> F SS#: _____ DATE OF BIRTH: _____
ADDRESS: _____	CITY: _____ STATE: _____ ZIP CODE: _____
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 me, my account will be distributed in accordance with the Plan document.

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

Witness signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Must be signed by County Official or GEBCorp Regional Client Manager)

**Return completed forms to:**  
**GEBCorp**  
**400 Galleria Parkway**  
**Suite 1250**  
**Atlanta, GA 30339**  
**Attn: Administration**  
**FAX: 770-563-9356**