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

Plan Number: 5 9 8 ___ ___ ___

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*

_____ *Name of Employer*

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

_____ *Signature of Employee*

_____ *Notary Public (Signature)*

_____ *Date*

_____ *Commission Expires*

Agency keep **original**, employee keep a copy and **either fax form to: 1-973-712-7489 or email to: ADPRS.eforms@adp.com**
Housing Agency Retirement Trust, c/o ADP Retirement Services, PO Box 22669, Louisville, KY 40252-0669
PHONE: 1-888-801-3534

DEPT = RKOPSHART
TASK - CHGFORM

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