



# Beneficiary Designation

## Instructions

To designate a beneficiary or to change your existing beneficiary designation on your retirement plan, complete all applicable sections of this form and return it to Diversified at the above address.

- Initial designation
- Change of designation

## Section A. Employer Information

Company/  
Employer Name \_\_\_\_\_

Contract/Account No. \_\_\_\_\_ Affiliate No. \_\_\_\_\_ Division No. \_\_\_\_\_

## Section B. Participant Information

Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ (mm/dd/yyyy)

First Name/MI \_\_\_\_\_ Social Security No. \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_

Phone No./Ext. \_\_\_\_\_

E-mail Address \_\_\_\_\_

## Section C. Beneficiary Designation

This designation will apply to the account number above. You must designate a specific percentage for each beneficiary. Shares must be whole percentages and total 100%. If you do not indicate shares, benefits will be split equally among surviving beneficiaries. If additional space is needed to designate multiple beneficiaries, complete the Supplemental Beneficiary Designations page provided. If the named beneficiary is a trust, please specify the name and date of the trust, and the name of the trustee. *Note: If you are currently receiving required minimum distributions, do not use this form. Contact Diversified at 800-755-5801 (Retirement Counseling Group) to designate a beneficiary.*

### Primary Beneficiary(ies) - Will receive benefits in the event of your death.

Beneficiary Last Name \_\_\_\_\_

First Name/MI \_\_\_\_\_ Relationship \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Share of Benefits \_\_\_\_\_ %

### Contingent Beneficiary(ies) - Will receive benefits if no primary beneficiary is living at the time of your death.

Beneficiary Last Name \_\_\_\_\_

First Name/MI \_\_\_\_\_ Relationship \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Share of Benefits \_\_\_\_\_ %

## Section D. Participant Signature

I certify that the information provided on this form is correct and complete.

**X** \_\_\_\_\_ Date \_\_\_\_\_

Participant Signature

## Supplemental Beneficiary Designations

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Participant Name

Social Security No.

Primary Beneficiary  Contingent Beneficiary

Beneficiary Last Name

First Name/MI

Relationship

Mailing Address

City

State

Zip Code

Share of Benefits  %

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Primary Beneficiary  Contingent Beneficiary

Beneficiary Last Name

First Name/MI

Relationship

Mailing Address

City

State

Zip Code

Share of Benefits  %

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Primary Beneficiary  Contingent Beneficiary

Beneficiary Last Name

First Name/MI

Relationship

Mailing Address

City

State

Zip Code

Share of Benefits  %

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Primary Beneficiary  Contingent Beneficiary

Beneficiary Last Name

First Name/MI

Relationship

Mailing Address

City

State

Zip Code

Share of Benefits  %

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