

# CHANGE OF BENEFICIARY FORM



I designate the following person(s) below to receive payment of the value of my account upon my death. If no primary beneficiary(ies) survives me, I designate that the balance of my account be distributed to my contingent beneficiary(ies) below.

Name: \_\_\_\_\_  Per Stirpes \_\_\_\_\_ % Share  
 Social Security #: \_\_\_\_\_ Relationship: \_\_\_\_\_  Primary  Contingent  
 Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_  Per Stirpes \_\_\_\_\_ % Share  
 Social Security #: \_\_\_\_\_ Relationship: \_\_\_\_\_  Primary  Contingent  
 Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_  Per Stirpes \_\_\_\_\_ % Share  
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 City, State, Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_  Per Stirpes \_\_\_\_\_ % Share  
 Social Security #: \_\_\_\_\_ Relationship: \_\_\_\_\_  Primary  Contingent  
 Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_

PLEASE NOTE: If you designate more than one beneficiary or contingent beneficiary, the percentage allocations must add up to 100%

Special instructions: \_\_\_\_\_

I understand that if no beneficiary survives me or if my beneficiary(ies) cannot be located, the plan will distribute the benefits to my estate. I understand that if I fail to indicate share percentages, all benefits will be divided equally among the beneficiaries I designate.

PARTICIPANT SIGNATURE

DATE

NOTE: Spousal Content is required if the participant is a resident of a community property state and the designated Primary Beneficiary is not the participant's spouse. The spouse's signature must be witnessed by either (1) a representative of the plan or (2) a Notary Public.

Spousal Waiver: I hereby consent to the above beneficiary designation.

Spouse's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness of Notary: Subscribed and Sworn to me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

Notary Signature: \_\_\_\_\_ Commission Expiration Date: \_\_\_\_\_

**RETURN FORM TO:**

**Retirement Plan Consultants, LLC**  
 PO BOX 1264  
 Norfolk, NE 68702  
 Fax: 402-379-3818  
 Email: [admin@retirementplanconsultants.net](mailto:admin@retirementplanconsultants.net)