

BENEFICIARY DESIGNATION

Plan Name _____

Participant Name _____

Participant Social Security Number _____ - _____ - _____

I. Designation of Beneficiary

As a participant in the above Plan, I hereby designate the following as the primary and contingent Beneficiaries of my accumulated benefit that will be paid by reason of my death under the provisions of the Plan.

Primary Beneficiary: Phone # _____

Primary Beneficiary: Phone # _____

Name Relationship

Name Relationship

Address

Address

City State Zip Code

City State Zip Code

Social Security Number _____ - _____ - _____

Social Security Number _____ - _____ - _____

Percentage % _____

Percentage% _____

Contingent Beneficiary: Phone # _____

Contingent Beneficiary: Phone # _____

Name Relationship

Name Relationship

Address

Address

City State Zip Code

City State Zip Code

Social Security Number _____ - _____ - _____

Social Security Number _____ - _____ - _____

Percentage % _____

Percentage % _____

The Plan Trustee shall pay all accumulated benefit under the Plan by reason of death to the primary Beneficiary(ies). If no primary Beneficiary(ies) shall survive, then the benefit will be paid to the contingent Beneficiary(ies), if no contingent Beneficiary(ies) survive or are designated, then to the estate of the Participant. If more than one Beneficiary is designated, any benefits payable will be shared equally among the survivors unless otherwise provided herein.

Any Beneficiary Designations previously made by me are hereby revoked. The right to revoke or change any Beneficiary Designation is hereby reserved.

Participant's Signature

Date

II. Statement of Participant's Marital Status

(Note: If you are in the process of divorce, you are still considered married.)

- I am single.
- I am married and have designated my spouse as the primary beneficiary of 100% of my account balance.
- I have no knowledge of the whereabouts of my spouse.

If you are married and do not name your spouse as beneficiary, your spouse must sign the consent below.

III. Spousal Consent

I acknowledge that I am entitled to my spouse's account balance in the event of my spouse's death. I waive my right to such benefit and consent to the designation of beneficiary set forth above. If I am not named above as a beneficiary I will receive no benefit from this Plan.

Spouse's Signature

Date

Witnessed by:

Plan Representative or Notary Public

Date

Note to Participant: If your marital status should change, the completion of a new form is advised. Also, advise your human resources department of any changes in the name or address of any beneficiary. Forward changes to: Legacy Benefit Services, LLC, 5600 S. Quebec Street, Suite 141B, Greenwood Village, CO, 80111.
Fax 303-996-6094.