

**Adventist Retirement Plan**  
**Alternate Beneficiary Designation Form**  
Plan ID# SDA403B

**New Enrollment**                       **Beneficiary Change**

**Name:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**Primary Beneficiary Designation**

I, the undersigned Participant, hereby direct that upon my death, my vested account balance in the Plan shall be delivered to the following Primary Beneficiaries or whichever of them survives me. I further understand that if more than one beneficiary is designated, the Plan distribution will be divided among all primary beneficiaries still living as described below (percentages indicated below should be whole numbers and when added must equal 100%). If any primary beneficiary is not living at the time of distribution, that beneficiary's portion shall be divided among the remaining beneficiaries proportionally.

	<b>Primary Beneficiary #1</b>	<b>Primary Beneficiary #2</b>	<b>Primary Beneficiary #3</b>
Name:	_____	_____	_____
SSN:	_____	_____	_____
Relationship:	_____	_____	_____
Address:	_____	_____	_____
City:	_____	_____	_____
StateZip:	_____ / _____	_____ / _____	_____ / _____
Date of Birth/%	_____ / ____%	_____ / ____%	_____ / ____%

**Contingent Beneficiary Designation**

If none of the above-named Primary Beneficiaries shall survive me, my vested account in the Plan shall be delivered to the following Contingent Beneficiaries or whichever of them survives me. I further understand, that if more than one beneficiary is designated, the Plan distribution will be divided among all contingent beneficiaries still living as described below (percentages indicated below should be whole numbers and when added must equal 100%). If any contingent beneficiary is not living at the time of distribution, that beneficiary's portion shall be divided among the remaining beneficiaries proportionally.

	<b>Contingent Beneficiary #1</b>	<b>Contingent Beneficiary #2</b>	<b>Contingent Beneficiary #3</b>
Name:	_____	_____	_____
SSN:	_____	_____	_____
Relationship:	_____	_____	_____
Address:	_____	_____	_____
City:	_____	_____	_____
StateZip:	_____ / _____	_____ / _____	_____ / _____
Date of Birth/%	_____ / ____%	_____ / ____%	_____ / ____%

**Employee Signature**

I authorize the beneficiary designations indicated on this form and attest to the accuracy of the information contained therein. **This form superceded all other beneficiary designation forms previously filed.**

Check if applicable:  Not Married     Missing Spouse     I want my spouse to be permitted to change my beneficiary designation if he or she survives me.  
[Note: If you do not check this box, no changes in this beneficiary designation can be made after your death.]

\_\_\_\_\_  
Employee (Print full name)

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**Spousal Consent**

If you are married, your spouse must complete the following:

I, \_\_\_\_\_ (print spouse's name), understand that my consent to a primary beneficiary other than myself is strictly voluntary. I hereby consent that I agree to the beneficiary designation(s) listed on this form. I understand that upon the death of my spouse THE PROCEEDS FROM THE PLAN WILL BE DISTRIBUTED EXACTLY AS SPECIFIED ON THIS FORM.

Spouse's Address: \_\_\_\_\_

Spouse's SS#: \_\_\_\_\_

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

**Employer or Notary Signature (Required)**

This section is only to be used for a Notary Public's witnessing of the Spousal Consent in absence of the employers witness.

State of \_\_\_\_\_, County of \_\_\_\_\_, On this \_\_\_\_\_ day of \_\_\_\_\_, in the year \_\_\_\_\_, Personally appeared \_\_\_\_\_.

The subscriber, known to me to be the person described in and who executed the foregoing instrument and he/she acknowledged to me that he/she executed the same.

\_\_\_\_\_  
Employer or Notary Signature (Required)

\_\_\_\_\_  
Date

NOTE: Multiple beneficiary designations are paid on a *per capita* basis. If any one of the beneficiaries dies prior to distribution of any Plan benefits, his or her share will be divided equally among and paid to the surviving beneficiaries.

**Return This Form to Your Local Payroll Office**

Questions about this form may be directed to 1-888-568-2542, Monday through Friday, 8:00 a.m. to 6:00 p.m. Eastern