Beneficiary Designation
Governmental 457(b) Plan

Use black or blue ink when completing this form. For questions regarding this form, contact Service Provider at 1-800-701-8255.

88048-01 Ketchikan Gateway Borough Deferred Compensation Plan

A Participant Information

Social Security Number | Account Extension

Account extension identifies funds transferred to a beneficiary due to death, alternate payee due to divorce or a participant with multiple accounts.

Last Name | First Name | M.I. | Date of Birth / /

Street Address | Personal Phone Number ( )

City | State | Zip Code | Work Phone Number ( )

Email Address | ❑ Married ❑ Unmarried

B Primary Beneficiary Designation (Attach an additional sheet to name additional beneficiaries.)

% of Account Balance | Primary Beneficiary Name | Relationship

% of Account Balance | Primary Beneficiary Name | Relationship

% of Account Balance | Primary Beneficiary Name | Relationship

Contingent Beneficiary Designation

% of Account Balance | Contingent Beneficiary Name | Relationship

% of Account Balance | Contingent Beneficiary Name | Relationship

% of Account Balance | Contingent Beneficiary Name | Relationship

C Signatures and Consent

Participant Consent

I have completed, understand and agree to all pages of this Beneficiary Designation form. Subject to and in accordance with the terms of the Plan, I am making the above beneficiary designations for my vested account in the event of my death. If I have more than one primary beneficiary, the account will be divided as specified. If a primary beneficiary predeceases me, his or her benefit will be allocated to the surviving primary beneficiaries. Contingent beneficiaries will receive a benefit only if there is no surviving primary beneficiary, as specified. If a contingent beneficiary predeceases me, his or her benefit will be allocated to the surviving contingent beneficiaries. If I fail to designate beneficiaries, amounts will be paid pursuant to the terms of the Plan or applicable law. This designation is effective upon execution and delivery to Plan Administrator/Trustee. If any information is missing, additional information may be required prior to recording my designation.

This designation supersedes all prior designations. Beneficiaries will share equally if percentages are not provided and any amounts unpaid upon death will be divided equally. **Primary and contingent beneficiaries must separately total 100% in whole percentages.**

I understand that Service Provider is required to comply with the regulations and requirements of the Office of Foreign Assets Control, Department of the Treasury ("OFAC"). As a result, Service Provider cannot conduct business with persons in a blocked country or any person designated by OFAC as a specially designated national or blocked person. For more information, please access the OFAC Web site at: http://www.treasury.gov/about/organizational-structure/offices/Pages/Office-of-Foreign-Assets-Control.aspx.

Any person who presents false or fraudulent information is subject to criminal and civil penalties.

Participant Signature _____ **Date *(Required)*** _____

Authorized Plan Administrator/Trustee Signature

I accept the information provided by the participant on this form.

Authorized Plan Administrator/Trustee Signature _____ **Date *(Required)*** _____

Last Name	First Name	M.I.	Social Security Number	88048-01 Number

D Mailing Instructions

Participant forward to Employer

Employer DO NOT send this form to the Service Provider as beneficiary records are not maintained. Please retain this for your records.

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