



Beneficiary Designation 401(a) Plan

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

98993-02 CERF Savings Plan - 401(a) Plan

A Participant Information				
Social Security Number _____		Account Extension _____		
Last Name _____		First Name _____	M.I. _____	Date of Birth _____ ()
Street Address _____		Personal Phone Number _____ ()		
City _____	State _____	Zip Code _____		Work Phone Number _____
Email Address _____		<input type="checkbox"/> Married <input type="checkbox"/> Unmarried		
Division/Location _____				

B Primary Beneficiary Designation (Attach an additional sheet to name additional beneficiaries.)				
%	Primary Beneficiary Name	Relationship	Social Security Number	Date of Birth / /
%	Primary Beneficiary Name	Relationship	Social Security Number	Date of Birth / /
%	Primary Beneficiary Name	Relationship	Social Security Number	Date of Birth / /

Contingent Beneficiary Designation				
%	Contingent Beneficiary Name	Relationship	Social Security Number	Date of Birth / /
%	Contingent Beneficiary Name	Relationship	Social Security Number	Date of Birth / /
%	Contingent Beneficiary Name	Relationship	Social Security Number	Date of Birth / /

C Signatures and Consent	
Participant Consent	
<p>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 Service Provider. If any information is missing, additional information may be required prior to recording my designation.</p> <p>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.</p> <p>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.</p> <p>Any person who presents false or fraudulent information is subject to criminal and civil penalties.</p>	
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

Number

D Mailing Instructions**Participant** forward to Great-West Retirement Services®**Great-West Retirement Services®** forward to Service Provider

Great-West Retirement Services®

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