

# Participant Beneficiary Form



Mark all that apply:  457(b) Plan  401(a) Plan  Defined Benefit  
 (if not checked, form applies to all Plans)

PARTICIPANT NAME: \_\_\_\_\_ TEL/EMAIL: \_\_\_\_\_

SOCIAL SECURITY NO.: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

- If you are designating multiple beneficiaries, please be sure to mark "Primary" or "Contingent" for each.
- If you name more than one primary or contingent beneficiary, the "Percent to Beneficiary" for that category must equal 100%.
- The "Percent to Beneficiary" can be split up to two decimal points. (Example: 33.33%.)
- Sign, witness, and date the form, certifying the information.
- If more space is needed, an additional sheet may be attached to this form.
- Defined Benefit Plan: The beneficiary(ies) designated on this form relates only to the receipt of lump sum or balance of period certain benefits payable.

Primary Beneficiary	
NAME: _____	<input type="checkbox"/> M <input type="checkbox"/> F SS#: _____ DATE OF BIRTH: _____
ADDRESS: _____	CITY: _____ STATE: _____ ZIP CODE: _____
RELATIONSHIP TO PARTICIPANT: _____	PERCENT TO BENEFICIARY: _____

**PLEASE CHECK PRIMARY OR CONTINGENT FOR ALL ADDITIONAL BENEFICIARIES**

PRIMARY <input type="checkbox"/>	CONTINGENT <input type="checkbox"/>
NAME: _____	<input type="checkbox"/> M <input type="checkbox"/> F SS#: _____ DATE OF BIRTH: _____
ADDRESS: _____	CITY: _____ STATE: _____ ZIP CODE: _____
RELATIONSHIP TO PARTICIPANT: _____	PERCENT TO BENEFICIARY: _____

PRIMARY <input type="checkbox"/>	CONTINGENT <input type="checkbox"/>
NAME: _____	<input type="checkbox"/> M <input type="checkbox"/> F SS#: _____ DATE OF BIRTH: _____
ADDRESS: _____	CITY: _____ STATE: _____ ZIP CODE: _____
RELATIONSHIP TO PARTICIPANT: _____	PERCENT TO BENEFICIARY: _____

PRIMARY <input type="checkbox"/>	CONTINGENT <input type="checkbox"/>
NAME: _____	<input type="checkbox"/> M <input type="checkbox"/> F SS#: _____ DATE OF BIRTH: _____
ADDRESS: _____	CITY: _____ STATE: _____ ZIP CODE: _____
RELATIONSHIP TO PARTICIPANT: _____	PERCENT TO BENEFICIARY: _____

PRIMARY <input type="checkbox"/>	CONTINGENT <input type="checkbox"/>
NAME: _____	<input type="checkbox"/> M <input type="checkbox"/> F SS#: _____ DATE OF BIRTH: _____
ADDRESS: _____	CITY: _____ STATE: _____ ZIP CODE: _____
RELATIONSHIP TO PARTICIPANT: _____	PERCENT TO BENEFICIARY: _____

Return completed forms to your employer for electronic submission through our secure website, or mail to:

ACCG Retirement Services  
 191 Peachtree Street NE  
 Suite 700  
 Atlanta, Georgia 30303

**You have the right to revoke or change any beneficiary designation.**

The Trustee will pay all sums payable under the Plan by reason of my death to the primary beneficiary, if they survive me. If no primary beneficiary survives me, then the contingent beneficiary will be paid all sums payable under the Plan by reason of my death. If no named beneficiary survives me, my account will be distributed in accordance with the Plan document.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Required Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name of Witness: \_\_\_\_\_

(Witness must not be listed as a beneficiary)