



MO Deferred Comp Plan BENEFICIARY DESIGNATION FORM

Select Plan(s) below:

☐ All Plans

☐ MO Deferred Comp 457 Plan - 626681

☐ MO Deferred Comp Incentive Plan- 626683

☐ MO Deferred Comp 457 Plan Bene - 626682

☐ MO Deferred Comp Incentive Plan Bene - 626684

PERSONAL INFORMATION (please print clearly using black or blue ink)

NAME: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____ APT: _____

CITY: _____ STATE: _____ ZIP CODE: _____

MOBILE PHONE: _____ DAY PHONE: _____ EVENING PHONE: _____

EMAIL: _____ DATE OF BIRTH: ____/____/____

MARITAL STATUS:

☐ I am married. If my spouse is not the sole Primary Beneficiary, my spouse has signed the spousal consent. If my spouse does not sign such consent, I understand that any death benefits under the Plan will automatically be payable in full to my surviving spouse.

INSTRUCTIONS

1. Use this form **ONLY** if you are married and designating someone other than, or in addition to, your spouse as your primary beneficiary.
2. If you are single, or if married and naming your spouse as your sole primary beneficiary, you must make or change your beneficiary designations by going online at www.modeferredcomp.org or speaking with a Customer Service Associate at 1-800-392-0925 (TTY/TTD users call 1-800-579-5708).
3. If you designate a trust as a beneficiary, please include the trust name and trust date.
4. If you are married, please note that your sole Primary Beneficiary must be your spouse unless you complete the Spousal Consent section of this form.
5. If you list more than one beneficiary, the total of all Primary and/or Contingent Beneficiaries must be in whole increments and equal 100%. If you need to add additional names, please use a separate piece of paper clearly labeling Primary or Contingent Beneficiaries.
6. If your Primary Beneficiary(ies) die(s) before you, then Plan benefits will be distributed to Contingent Beneficiary(ies).

PRIMARY BENEFICIARY(IES)

Full Name and Address	Social Security Number	Date of Birth	Relationship to You	Percent of Benefit* (Whole % only, must total 100%)
1 _____ _____ _____	_____	____/____/____ MM DD YYYY		____.00%
2 _____ _____ _____	_____	____/____/____ MM DD YYYY		____.00%
3 _____ _____ _____	_____	____/____/____ MM DD YYYY		____.00%
4 _____ _____ _____	_____	____/____/____ MM DD YYYY		____.00%
*A Percent of Benefit must be provided for each Primary Beneficiary, even if only a single beneficiary is listed. The percent assigned to each Primary Beneficiary must be in whole increments and must total to 100%. Both of these requirements must be met in order for this form to be accepted and processed.				100%

SPOUSAL CONSENT (If spouse is not the sole Primary Beneficiary)

Your spouse must consent and acknowledge by signing below if he/she is not the sole Primary Beneficiary.

I hereby consent to the foregoing election by my spouse, to have his/her benefits paid to a person other than me. I understand **(1)** that the effect of such designation is to cause my spouse's death benefit to be paid to a beneficiary other than me; **(2)** that each beneficiary designated is not valid unless I consent to it; and **(3)** that my consent is irrevocable unless my spouse revokes the beneficiary designation.

I hereby acknowledge that I have had the opportunity to consult with an attorney or other professional concerning this waiver, if I had so desired.

Executed this _____ day of _____ 20 _____

Spouse's Signature _____

Print Name _____

WITNESSED BY:

Notary Signature _____

Print Name _____

State _____ County _____ My Commission expires _____

CONTINGENT BENEFICIARY(IES)

Full Name and Address	Social Security Number	Date of Birth	Relationship to You	Percent of Benefit* (Whole % only, must total 100%)
1 _____ _____ _____	_____	____/____/____ MM DD YYYY		____.00%
2 _____ _____ _____	_____	____/____/____ MM DD YYYY		____.00%
3 _____ _____ _____	_____	____/____/____ MM DD YYYY		____.00%
4 _____ _____ _____	_____	____/____/____ MM DD YYYY		____.00%
*A Percent of Benefit must be provided for each Contingent Beneficiary, even if only a single beneficiary is listed. The percent assigned to each Contingent Beneficiary must be in whole increments and must total to 100%. Both of these requirements must be met in order for this form to be accepted and processed.				100%

AUTHORIZATION

Subject to the spousal consent requirements, I understand that I may revoke or change this designation at any time by filing a new designation of beneficiary in writing with the MO Deferred Comp Plan and that by doing so, I revoke all prior designations.

I understand that if none of the above-named beneficiary(ies) survive me, all benefits under the Plan will be distributed according to the provisions stated in the official plan document.

I hereby certify that the information I furnished herein is true, accurate and complete.

PARTICIPANT SIGNATURE _____ DATE _____

CHECKLIST

PLEASE REVIEW YOUR APPLICATION CAREFULLY.

- ☐ Read the required instructions.
- ☐ Provided complete personal information including name, Social Security number and marital status.
- ☐ Provided your Primary Beneficiary(ies). Make sure you have completed all the sections and that your percentages of benefit total 100%.
- ☐ Had the Spousal Consent section signed and notarized (with an official notary stamp or seal) if you are married and do not name your spouse as your sole Primary Beneficiary.
- ☐ Completed the Contingent Beneficiaries section (only if you want to have contingent beneficiaries). The total percent equals 100% of benefit.
- ☐ Listed the name, address, Social Security number, birth date and relationship of all Beneficiaries.
- ☐ Signed and dated your Beneficiary Designation (Authorized Signature).
- ☐ Made a copy for your records and send the original to MO Deferred Comp Plan.

You will receive a confirmation statement on your beneficiary elections. If you have any questions or need to obtain additional plan or account information, please go online at www.modeferredcomp.org or call the MO Deferred Comp Service Center at 1-800-392-0925 (TTY/TTD users call 1-800-579-5708). Customer Service Associates are available Monday through Friday, 7:00 A.M. to 7:00 P.M. Central Time (excluding stock market holidays).

If your application is complete, please mail or fax the application and any additional documents to:

VIA FAX

Attn: MO Deferred Comp
1-855-545-2212

VIA MAIL

Attn: MO Deferred Comp
P.O. Box 389
Hartford, CT 06141

VIA OVERNIGHT DELIVERY

Attn: MO Deferred Comp
One Orange Way
Windsor, CT 06095