



DEATH BENEFIT ELECTION

DBE

To be completed by the beneficiary of a deceased Participant eligible to receive Benefits

I. Deceased Participant Information

Name (First _____ Middle _____ Last _____)			Social Security Number		
Last Address (Street) _____			Date of Birth: _____ (Month/Day/Year)		
(City _____ State _____ Zip Code _____)			Date of Death: _____ (Month/Day/Year)		
			Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male		

II. Claimant Information

Name (First _____ Middle _____ Last _____)			Social Security Number		
Address (Street) _____			Date of Birth: _____ (Month/Day/Year)		
(City _____ State _____ Zip _____)			(area code) _____ Home Telephone Number		
			(area code) _____ Work Telephone Number		
Relationship to Participant: _____					

III. Benefit Options

I elect to apply for the following benefit option (choose one). – Please read the enclosed Special Tax Notice for more information.

- Option A: Annuity Payments** – This option is **only** available to accounts exceeding \$5,000.
 - Based upon 50% of the account plus a 50% single sum payment based upon the balance
 - OR**
 - 100% of the total account balance.
- Option B: Single Sum Payment** – a single, one time payment of the *total* balance of the Retirement account. I understand that a mandatory 20% federal income tax will be withheld from the taxable portion of this payment unless I elect to rollover. If you wish to rollover your benefit, please complete information below.
- Option C: Rollover To My IRA**

Amount: : _____ % of Distribution or \$ _____ Account Number: _____

Name of IRA Rollover Account: _____

Name of Financial Institution: _____

Address of Financial Institution: _____
- Option D: Rollover To My Employer’s Qualified Retirement Plan**

It is your obligation to insure that the Employer Plan named will accept the transfer of your benefit payment.

Amount: _____ % of Distribution or \$ _____ Account Number: _____

Name of Plan: _____

Name of Employer: _____

Address of Employer: _____

Signature of Plan Officer: _____ **Date:** _____

IV. Signature of Claimant

The information provided above is accurate as of the date of my signature and it reflects my wishes with respect to any death benefit. I understand that this election is irrevocable and cannot be changed, withdrawn or cancelled once processed.

► **Signature** _____ Date _____
(Signature must be witnessed by Notary Public)

TO BE COMPLETED BY NOTARY PUBLIC

State of _____ County of _____

On this _____ day of _____, 20____ personally appeared before me, the said _____, to be known to be the individual described in and who executed the foregoing instrument, who duly acknowledged to me that she or he executed the same, and being duly sworn by me, made oath that the statements therein contained are true to the best of her or his knowledge and belief.

NOTARY PUBLIC _____
Sign and Certify with Stamp or Seal