



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: _____		Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	
(City State Zip Code)			Date of Death: _____		month/day/year	

II. Claimant Information

Name (First Middle Last)			Social Security Number			
Address (Street)			Date of Birth: _____		Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	
(City State Zip)			(area code) _____		(area code) _____	
Relationship to Participant: _____			Home Telephone Number		Work Telephone Number	

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. I further understand that if I reside in the state of Connecticut a mandatory **6.99% state income tax** will also be withheld from the taxable portion of this payment.

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 Another 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 I understand that this election is irrevocable and cannot be changed, withdrawn or cancelled once processed.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 me 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