

TERMINATION PAY AND PAY FOR UNUSED SICK LEAVE BENEFICIARY DESIGNATION

Initial Beneficiary Designation(s) **OR** Change of All Prior Beneficiary Designation(s) (check one box only)

I hereby revoke any previous beneficiary designation(s), if any, for my termination pay and pay for unused sick leave and direct that the monies payable for termination pay and unused sick leave be paid as indicated below.

Name	Social Security Number
Address	Telephone Number

NAMING THE BENEFICIARY

It is important that your beneficiary designation be clear so that there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. When naming beneficiary(ies), please supply all requested information. If the beneficiary is not related either by blood or by marriage, insert the words "Not Related". **NOTE:** Whether designating one or more beneficiaries, the total Benefit Percent must equal 100%.

PRIMARY BENEFICIARY(IES) I hereby name the following beneficiary(ies). If I have named more than one beneficiary, it is my intention that those living at the time of my death share in the benefit payable as indicated below. I reserve the right to change this designation at any time.

Name: _____ Date of Birth: _____
 Address: _____
 Social Security Number: _____ Relationship: _____
 Benefit Percent: _____

Name: _____ Date of Birth: _____
 Address: _____
 Social Security Number: _____ Relationship: _____
 Benefit Percent: _____

CONTINGENT BENEFICIARY(IES) If all designated primary beneficiaries predecease me, any benefit payable on my behalf shall be paid to the following. If I have named more than one contingent beneficiary, it is my intention that those living at the time of my death should share in the benefit payable as indicated below. Furthermore, if I survive these beneficiaries, any benefit payable should be paid to my estate or any other beneficiary I name thereafter. I reserve the right to change this designation at any time.

Name: _____ Date of Birth: _____
 Address: _____
 Social Security Number: _____ Relationship: _____
 Benefit Percent: _____

Name: _____ Date of Birth: _____
 Address: _____
 Social Security Number: _____ Relationship: _____
 Benefit Percent: _____

This form must be signed and notarized in order to be valid

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

Signature of Insured _____ Date _____

State of _____ County of _____

Sworn before me this _____ day of _____ 20 _____

 Notary Public