

BENEFICIARY DESIGNATION FORM

Complete this form to designate beneficiaries who will receive your 457 Plan benefits in the event of your death.

Initial Enrollment

Change of Beneficiary

I. PARTICIPANT INFORMATION

Participant Name: _____ Social Security Number _____ - _____ - _____

Telephone Number(s) () _____ Wk Mailing Address _____ Street

() _____ Hm

City State Zip

II. EMPLOYER INFORMATION

Employer Name: _____ Employer Plan Number: 450 _____

III. BENEFICIARY INFORMATION

In the event of your death, your 457 account will be paid to the primary beneficiary(ies) you name below. If your primary beneficiary(ies) is not living at the time of your death, your 457 account will be paid to the secondary (contingent) beneficiary(ies) you name below. You may name a Trust as a primary or secondary beneficiary.

Primary Beneficiary (ies) (attach separate sheet if necessary)

	Last Name	First	M.I.	Social Security No.	Relationship/ Date of Birth	Percentage
1.	_____	_____	_____	____ - ____ - ____	_____	_____
2.	_____	_____	_____	____ - ____ - ____	_____	_____
3.	_____	_____	_____	____ - ____ - ____	_____	_____
4.	_____	_____	_____	____ - ____ - ____	_____	_____

Secondary (Contingent) Beneficiary (ies)

	Last Name	First	M.I.	Social Security No.	Relationship/ Date of Birth	Percentage
1.	_____	_____	_____	____ - ____ - ____	_____	_____
2.	_____	_____	_____	____ - ____ - ____	_____	_____
3.	_____	_____	_____	____ - ____ - ____	_____	_____
4.	_____	_____	_____	____ - ____ - ____	_____	_____

III. PARTICIPANT'S SIGNATURE

CalPERS 457 DEFERRED COMPENSATION PROGRAM

I hereby revoke all previous designations of beneficiary for this plan. I certify that the information in Section III is correct; and reserve the right to change my Beneficiary Designation at any time by completing a new form and filing it with the CalPERS 457 Program.

Participant's Signature _____ Date ____/____/____