



# Beneficiary form

Case number: 226-80567 // VOLUNTEERS OF AMERICA CHESAPEAKE, INC.  
EMPLOYEE TDA PLAN

## Participant information

Social Security number: \_\_\_\_\_ Last/first/MI name: \_\_\_\_\_

<b>A</b>	Enter primary beneficiary Information.	Percentages must total 100%	Percentage of benefits
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If married, your spouse must be the only primary beneficiary unless your spouse signs the waiver in Section D.

Last/first/MI name: \_\_\_\_\_ Relationship: \_\_\_\_\_ %

Address: \_\_\_\_\_ SSN: \_\_\_\_\_

Last/first/MI name: \_\_\_\_\_ Relationship: \_\_\_\_\_ %

Address: \_\_\_\_\_ SSN: \_\_\_\_\_

<b>B</b>	Enter contingent beneficiary Information.	Percentages must total 100%	Percentage of benefits
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In the event that your primary beneficiaries do not survive you, your vested account balance will be divided among your contingent beneficiaries in the percentages specified below.

Last/first/MI name: \_\_\_\_\_ Relationship: \_\_\_\_\_ %

Address: \_\_\_\_\_ SSN: \_\_\_\_\_

Last/first/MI name: \_\_\_\_\_ Relationship: \_\_\_\_\_ %

Address: \_\_\_\_\_ SSN: \_\_\_\_\_

Last/first/MI name: \_\_\_\_\_ Relationship: \_\_\_\_\_ %

Address: \_\_\_\_\_ SSN: \_\_\_\_\_

Last/first/MI name: \_\_\_\_\_ Relationship: \_\_\_\_\_ %

Address: \_\_\_\_\_ SSN: \_\_\_\_\_

Last/first/MI name: \_\_\_\_\_ Relationship: \_\_\_\_\_ %

Address: \_\_\_\_\_ SSN: \_\_\_\_\_

<b>C</b>	Complete and sign.
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I certify that I am:  Married  Not married  Legally separated

Participant signature \_\_\_\_\_ Date \_\_\_\_\_

Last/first/MI name \_\_\_\_\_

SSN \_\_\_\_\_

**D** This section must be completed if your spouse is not the sole primary beneficiary.

I consent to the primary beneficiary designation(s) made by my spouse. I understand that I have the right to all of my spouse's vested account under this Plan after my spouse dies. I understand that by signing this consent, I am giving up my right to some or all of the benefits under this Plan, that the designation is not valid unless I consent to it, and that my consent is irrevocable unless my spouse revokes the beneficiary designation.

Spouse's name: \_\_\_\_\_

Spouse signature: \_\_\_\_\_ Date: \_\_\_\_\_

This consent must be witnessed by either a Plan Representative or a Notary Public.

State of: \_\_\_\_\_ County of: \_\_\_\_\_

I certify that before me personally appeared the above-named spouse who signed the above spousal consent and acknowledged the same to be his/her free act and deed.

Plan Representative signature or Notary Public: \_\_\_\_\_ Date: \_\_\_\_\_

Notary Public Commission expires: \_\_\_\_\_ (Notary Seal)

**E** Read, complete and sign.

If you are a married participant in a qualified retirement plan, the law requires that upon your death your Plan account balance be paid to your spouse in the form of a Qualified Pre-retirement Survivor Annuity (QPSA). A QPSA will periodically distribute your retirement account to your spouse over his/her lifetime. The size of each payment will be based upon your Plan account balance at the time of your death.

You may elect to waive that your surviving spouse be paid in the form of a QPSA. You may elect to waive the QPSA beginning on the day you become a participant in the Plan. Any waiver you sign before age 35 will become invalid the first day of the Plan year in which you are age 35. At that time you may waive the QPSA and the requirement that your spouse be your beneficiary. Your spouse must consent in writing to this waiver. You may revoke any waiver that you have made at any time before your death. Your spouse must consent to any changes of beneficiary. If your vested account balance is \$5,000 or less, upon your death the Plan Administrator may make a distribution to your surviving spouse in a single sum cash payment even if you did not waive the QPSA.

You should immediately notify your Plan Administrator of any change in your marital status. A change may require you to complete a new Designation of Beneficiary Form. For more information regarding Qualified Pre-retirement Survivor Annuities, contact your Plan Administrator.

- Employee Waiver:** As a married employee in the Plan, I have read the information about Qualified Pre-retirement Survivor Annuities. I waive the requirement that, upon my death, my spouse be paid my benefits in the form of a Qualified Pre-retirement Survivor Annuity. I understand and agree that this waiver is valid only if my spouse understands and signs the statement below.

Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- Spousal Consent to Waiver:** I am the spouse of the employee named above. I understand and agree that his/her benefits are not to be paid in the form of a Qualified Pre-retirement Survivor Annuity upon death. I understand that my consent remains in effect unless my spouse revokes the above waiver. The spouse's signature must be witnessed by a notary public.

Spouse signature: \_\_\_\_\_ Date: \_\_\_\_\_

Sworn to, and witnessed by me, this \_\_\_\_\_ day of \_\_\_\_\_ (month) \_\_\_\_\_

Name of Notary Public: \_\_\_\_\_

Plan Representative signature or Notary Public: \_\_\_\_\_

**Additional information**

You may make a written request to your Plan Administrator requesting a personalized statement describing the effect of electing an optional form of benefit and providing a comparison of the relative values under each available optional form of benefit.

**Please return this completed form to your Human Resources Representative.**