



Submit completed form to:
County Employees' Retirement Fund
2121 Schotthill Woods Drive
Jefferson City, MO 65101
Toll Free: 877-632-2373
Fax: 573-761-4404

BENEFICIARY DESIGNATION-SINGLE VESTED DEATH BENEFIT

*The participant completes and signs this form. If you are single, obtain vested status, and die, your beneficiary(s) will receive a refund of your CERF contributions. These benefits are in addition to the CERF \$10,000 death benefit payable to your named beneficiary(s). **PAGE 2 MUST BE SIGNED BY THE PARTICIPANT.***

PARTICIPANT INFORMATION

Social Security Number _____ - _____ - _____ County of Employment _____

First Name _____ Initial _____ Last Name _____ Suffix _____

PRIMARY BENEFICIARIES OF SINGLE DEATH CONTRIBUTION BENEFIT

Percentage of Benefit for ALL primary beneficiaries must total 100%.

Social Security Number _____ - _____ - _____ Relation to Participant _____ Percentage of Benefit _____

First Name _____ Initial _____ Last Name _____ Suffix _____

Address _____ City _____ State _____ Zip _____

Home Phone/Cell (_____) _____ Gender Male Female Date of Birth _____ / _____ / _____

Social Security Number _____ - _____ - _____ Relation to Participant _____ Percentage of Benefit _____

First Name _____ Initial _____ Last Name _____ Suffix _____

Address _____ City _____ State _____ Zip _____

Home Phone/Cell (_____) _____ Gender Male Female Date of Birth _____ / _____ / _____

Social Security Number _____ - _____ - _____ Relation to Participant _____ Percentage of Benefit _____

First Name _____ Initial _____ Last Name _____ Suffix _____

Address _____ City _____ State _____ Zip _____

Home Phone/Cell (_____) _____ Gender Male Female Date of Birth _____ / _____ / _____

Social Security Number _____ - _____ - _____ Relation to Participant _____ Percentage of Benefit _____

First Name _____ Initial _____ Last Name _____ Suffix _____

Address _____ City _____ State _____ Zip _____

Home Phone/Cell (_____) _____ Gender Male Female Date of Birth _____ / _____ / _____

Social Security Number _____ - _____ - _____ Relation to Participant _____ Percentage of Benefit _____

First Name _____ Initial _____ Last Name _____ Suffix _____

Address _____ City _____ State _____ Zip _____

Home Phone/Cell (_____) _____ Gender Male Female Date of Birth _____ / _____ / _____

Social Security Number _____ - _____ - _____ Relation to Participant _____ Percentage of Benefit _____

First Name _____ Initial _____ Last Name _____ Suffix _____

Address _____ City _____ State _____ Zip _____

Home Phone/Cell (_____) _____ Gender Male Female Date of Birth _____ / _____ / _____

Continue to Page 2 for Contingent Beneficiary Designation(s) and REQUIRED Participant Signature

CONTINGENT BENEFICIARIES OF SINGLE DEATH CONTRIBUTION BENEFIT

Percentage of Benefit for ALL contingent beneficiaries must total 100%.

Social Security Number _____ - _____ - _____ Relation to Participant _____ Percentage of Benefit _____

First Name _____ Initial _____ Last Name _____ Suffix _____

Address _____ City _____ State _____ Zip _____

Home Phone/Cell (_____) Gender Male Female Date of Birth ____ / ____ / ____

Social Security Number _____ - _____ - _____ Relation to Participant _____ Percentage of Benefit _____

First Name _____ Initial _____ Last Name _____ Suffix _____

Address _____ City _____ State _____ Zip _____

Home Phone/Cell (_____) Gender Male Female Date of Birth ____ / ____ / ____

Social Security Number _____ - _____ - _____ Relation to Participant _____ Percentage of Benefit _____

First Name _____ Initial _____ Last Name _____ Suffix _____

Address _____ City _____ State _____ Zip _____

Home Phone/Cell (_____) Gender Male Female Date of Birth ____ / ____ / ____

Social Security Number _____ - _____ - _____ Relation to Participant _____ Percentage of Benefit _____

First Name _____ Initial _____ Last Name _____ Suffix _____

Address _____ City _____ State _____ Zip _____

Home Phone/Cell (_____) Gender Male Female Date of Birth ____ / ____ / ____

Social Security Number _____ - _____ - _____ Relation to Participant _____ Percentage of Benefit _____

First Name _____ Initial _____ Last Name _____ Suffix _____

Address _____ City _____ State _____ Zip _____

Home Phone/Cell (_____) Gender Male Female Date of Birth ____ / ____ / ____

Social Security Number _____ - _____ - _____ Relation to Participant _____ Percentage of Benefit _____

First Name _____ Initial _____ Last Name _____ Suffix _____

Address _____ City _____ State _____ Zip _____

Home Phone/Cell (_____) Gender Male Female Date of Birth ____ / ____ / ____

REQUIRED SIGNATURE – See Below

I am designating the above person(s) as my primary and contingent beneficiaries of my single death contribution benefit through the County Employees' Retirement Fund. If none of these persons are alive when I die, my benefit will be distributed in the manner provided by law. I revoke all prior designations regarding these funds. I reserve the right to revoke any designation by making another written designation. **Unless otherwise stated by me, my beneficiaries' interest in this benefit is as joint tenants with right of survivorship. The interest of any beneficiary (and related heirs) terminates if he or she dies before I do. The indicated share of the other beneficiaries will increase on a pro rata basis.** I understand these beneficiary designations will become void once I terminate from county employment.

Signature of Participant _____ **Date** _____

Home Phone (_____) _____

Social Security Number _____

Cell Phone (_____) _____