

**ST. LOUIS COUNTY RETIREMENT PLANS (PLAN A OR PLAN B)
CHANGE OF BENEFICIARY AND/OR CHANGE OR CORRECTION OF NAME**

PLEASE PRINT OR TYPE

RETIREE NAME _____ **SOCIAL SECURITY NO.** _____

SECTION I – CHANGE OF BENEFICIARY

I, the undersigned, a participant in _____ Plan A _____ Plan B, hereby revoke all previous designations of beneficiaries and designate the following to receive the benefits payable under the provisions of Chapter 204, SLCRO 1964 as amended, in the event of my death. I still reserve the privilege of other and future changes.

(a) PRIMARY BENEFICIARY OR BENEFICIARIES – If Beneficiary is a Minor (under age 18), please seek legal counsel.

NAME _____ Relationship _____ SSN: _____ Age: _____

Address _____

NAME _____ Relationship _____ SSN: _____ Age: _____

Address _____

NOTE: If more primary beneficiaries need to be listed please see the back of this form.

Or in the event no primary beneficiary is living at my death, then to:

(b) CONTINGENT BENEFICIARY OR BENEFICIARIES

NAME _____ Relationship _____ SSN: _____ Age: _____

Address _____

NAME _____ Relationship _____ SSN: _____ Age: _____

Address _____

If more than one beneficiary is designated, the benefits or sums payable because of my death shall be paid in equal shares to the designated beneficiaries (or beneficiary) who survive me. If no designated beneficiary survives me, payment will be made, in the Board's discretion, to any one or more of the surviving relatives of the participant or deceased beneficiary, as the case may be: Wife, husband, father, child or children, sister or sisters, brother or brothers.

SECTION II – CHANGE OR CORRECTION OF NAME

I, the undersigned, a participant in _____ Plan A _____ Plan B, hereby request that the name of the _____ Participant _____ Beneficiary _____ Survivor Annuitant previously designated under the provisions of Chapter 204, SLCRO 1964 as amended, appearing on the records of the Board of Trustees of the County Retirement Plans as:

_____ be changed to _____ because of

Signature of Participant

Signature of Witness

Date (Form Must Be Signed and Dated to be Effective)

(OVER)

(a) PRIMARY BENEFICIARY OR BENEFICIARIES (continued from front)

NAME _____ Relationship_____ SSN:_____ Age: _____

Address _____

NAME _____ Relationship_____ SSN:_____ Age: _____

Address _____

NAME _____ Relationship_____ SSN:_____ Age: _____

Address _____

NAME _____ Relationship_____ SSN:_____ Age: _____

Address _____

NAME _____ Relationship_____ SSN:_____ Age: _____

Address _____

NAME _____ Relationship_____ SSN:_____ Age: _____

Address _____

Received by Board and recorded _____ By: _____