

MONTGOMERY COUNTY

EMPLOYEE LIFE INSURANCE & RETIREMENT BENEFICIARY FORM

| | | | | |
|------------------------|-----------|------------|------|------------|
| SOCIAL SECURITY NUMBER | LAST NAME | FIRST NAME | M.I. | DEPT. NAME |
| -- -- | | | | |

Designation of Life Insurance Beneficiaries

Unless otherwise provided, where two or more beneficiaries are named, payment will be made in equal shares to the named beneficiaries who survive the Insured. If no beneficiary survives the Insured, payment will be made in accordance with the terms of the policy. *(Please fill out each section completely.)*

PRIMARY INSURANCE BENEFICIARY

| NAME | RELATIONSHIP | ADDRESS |
|------|--------------|---------|
| | | |
| | | |
| | | |

CONTINGENT *(To receive benefits if the primary beneficiary DOES NOT survive the insured)*

| NAME | RELATIONSHIP | ADDRESS |
|------|--------------|---------|
| | | |
| | | |
| | | |

Employee Signature

Date

Designation of Retirement Plan Beneficiaries

Part-time permanent employees may elect or decline membership in the retirement system.

As a part-time employee, do you wish to have retirement contributions taken? YES NO

PRIMARY RETIREMENT BENEFICIARY

| NAME | RELATIONSHIP | ADDRESS |
|------|--------------|---------|
| | | |
| | | |
| | | |

CONTINGENT *(To receive benefits if the primary beneficiary DOES NOT survive the insured)*

| NAME | RELATIONSHIP | ADDRESS |
|------|--------------|---------|
| | | |
| | | |
| | | |

Employee Signature

Date

Signature and Address of Witness

Rev. 10/99

FOR USE OF OFFICE OF HUMAN RESOURCES ONLY

RETIREMENT CODE: _____ HR SPECIALIST NAME: _____ DATE: _____



Montgomery County Maryland

DESIGNATION OF BENEFICIARY FOR SALARY, ANNUAL & SICK LEAVE

General Information: This form is used to designate the person(s) to receive all salary and other compensation to which an employee is legally entitled in the event the death of the employee occurs while employed by Montgomery County Government. An employee may change the beneficiary(ies) at any time by completing a new beneficiary designation form. The form on file with the most recent date will take precedence. (Pursuant to Section 33-26 of the Personnel Regulations)

Original Designation Change

(Print or Type)

Employee's Name: Social Security Number:

Employee's Address:

All salary and other compensation to which I am legally entitled from Montgomery County Government shall be paid to the following person(s) in the event of my death.

Beneficiary(ies) Name, Address and Relationship (indicate percentage if multiple designations are listed)

Multiple horizontal lines for beneficiary information.

Signature of Employee

Date Signed

Signature and Address of Witness

INSTRUCTIONS

- 1. This designation is for Montgomery County salary, annual and sick leave entitlement only and is effective only if your death occurs while you are an employee of Montgomery County Government. It does not affect your Life Insurance and Retirement beneficiary designations.
2. Your beneficiary need not be related to you. It is necessary that the complete name of the beneficiary be given. Example "Mary A. Jones" not "Mrs. James J. Jones."
3. A minor child may be designated, however, the employee cannot designate a Guardian for the minor child. The designation of a Guardian may be done by the employee's will. If you name a minor child, the Court will appoint a Guardian at the time of the death of the employee and a copy of the Court Order must be forwarded to the Payroll Section, Department of Finance, before payment can be made.
4. If you do not desire to name a person, you may name "my estate."
5. You may designate a charitable organization or church, but the complete corporate or legal name must be indicated.

PLEASE DO NOT STAPLE THIS FORM

MARKING INSTRUCTIONS

USE A NO. 2 PENCIL ONLY

CORRECT MARK (A) ● (C) WRONG MARKS ✓ ✗ W

**MONTGOMERY COUNTY
DEFERRED COMPENSATION PLAN
JOINER AGREEMENT AND CHANGE FORM**

ACTIVITY Choose all that apply:

- New enrollment
(Requires Investment Election and Beneficiary Forms)
- Change provider
(Requires Investment Election Form)
- Change in Beneficiary
- Change contribution amount(s)
- Suspend all contributions.
(Note: You may restart only during an open season.)

YOUR SOCIAL SECURITY NO.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 |
| 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 |
| 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 |
| 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 |
| 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 |

Participant: _____
Last Name First Name M.I.

Address: _____

Telephone: (____) _____ (____) _____
Home Work

CONTRIBUTION AND PROVIDER(S) SELECTION

For new enrollments, resumption of contributions, increases or decreases in contribution amounts, complete below:

- Indicate new total bi-weekly amount:
- Select provider(s) below and how much of item 1 you wish to allocate to provider(s). Note: You may choose one provider or both; however, totals must be equal to item 1. In making this selection, you are acknowledging that you understand and accept the terms and conditions of the services by the provider.

\$ _____

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 |
| 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 |
| 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 |
| 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 |
| 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 |

ITT Hartford
Amount of
Bi-Weekly
Contribution:

\$ _____

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 |
| 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 |
| 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 |
| 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 |
| 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 |

FIDELITY
Amount of
Bi-Weekly
Contribution:

\$ _____

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 |
| 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 |
| 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 |
| 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 |
| 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 |

Your indicated contribution will be made continuously on a bi-weekly basis until otherwise directed by you. Contribution TOTALS in a calendar year may not exceed the lesser of \$8,000.00 or 25% of your gross Montgomery County salary in that year, including any contributions made to another Deferred Compensation Plan that year. This limit increases to \$15,000 in years that you qualify to use the Catch-up provision. You must submit a change form prior to exceeding your contribution limit. The employer reserves the right to discontinue contributions if this limit is exceeded.

- Catch-Up Provision:** If you are participating in the Plan's Catch-up provision, mark here . You must have completed a Catch-up provision form and received confirmation of your qualification status. Contact Office of Human Resources to apply.
- Investment Election Form:** Attach an investment election form(s) from provider(s) selected. This form will not be processed without an investment election form attached unless you have previously submitted one to the provider selected.
 Have you attached an election form? Yes No

NOTIFICATION OF ACCEPTANCE

I wish to participate in the Deferred Compensation Plan and hereby agree to defer my right to receive compensation to the extent of the annual contributions noted above. I understand and agree to the provisions contained in my Employer's Deferred Compensation Plan. Further, I hold harmless my Employer from any liability hereunder for acts performed in good faith, including those related to the investment of deferred amounts and/or my Employer's investment options offered under my Employer's Compensation Plan.

Signature of employee acknowledges terms of the above agreement and acknowledges the delegation of the investment decisions to the Participant for the Participant's account balances. Note: You will receive a confirmation statement indicating changes made by you to your Deferred Compensation account. If you want a copy of this form, please make a copy of this form before submitting it to OHR.

Participant's signature: _____ Date: _____

BENEFICIARY AND PAYOUT DESIGNATION

You must complete the beneficiary section on the reverse side of this form for initial enrollment or changes in beneficiary.

BENEFICIARY AND PAYOUT DESIGNATION: Complete for initial enrollments, or addition of provider, or changes in beneficiary.

Please be advised that the Plan provides for a default payout arrangement in case of participant's death prior to termination of employment or retirement from County service. If a participant dies without having selected a form of distribution of benefits, the beneficiary may designate payments to such beneficiary in accordance with one of the available options provided under the Plan. Such selection must be made within 90 days of the death of the participant. If you wish to designate a beneficiary payout arrangement in lieu of the default arrangement, please indicate the selected payout method below:

Lump Sum Monthly payment for _____ years Annual Payment for _____ years Annuity

| NAME | RELATIONSHIP | ADDRESS | SOCIAL SECURITY # (IF AVAILABLE) | % OF BENEFIT |
|---|--------------|---------|-------------------------------------|-----------------|
| PRIMARY BENEFICIARY(IES) | | | | |
| CONTINGENT BENEFICIARY(IES) (If primary does not succeed you.) | | | | |