State of Arizona Retirement Plans

Beneficiary Change Form

Service Center: 800-891-4749 • Local Office: 602-266-2733

I. Personal Information

☐ **Check this box for Name Change** **Plan Type (mark all that apply):** ☐ 457 ☐ 403(b) ☐ 401(a)

Name: ______________________________ SSN: ______________

Street Address: ____

City: ______________________________ State: ________ Zip: ________

Date of Birth: ____________ Home Phone: ____________ Work Phone: ____________

Would you like this beneficiary information displayed on your quarterly statement? ☐ Yes ☐ No
(If this question is not marked, we will assume you want it displayed.)

As a participant in the above Deferred Compensation Plan, I do hereby revoke any previous beneficiary information submitted and specify the following.

II. Beneficiary Designation

☐ **Check here if this is a change of beneficiary.** (Beneficiaries listed below replace any prior designation)
NOTE: Percentage split must total 100% for each category of beneficiary.
If additional space for beneficiaries is required, attach additional sheets and mark this box: ☐

Primary Beneficiary(ies) (must total 100%):

Name:	Relationship:	Social Security #:	Phone #:
Address:		Date of Birth:	% Split:

Name:	Relationship:	Social Security #:	Phone #:
Address:		Date of Birth:	% Split:

Contingent Beneficiary(ies) (must total 100%):

Name:	Relationship:	Social Security #:	Phone #:
Address:		Date of Birth:	% Split:

Name:	Relationship:	Social Security #:	Phone #:
Address:		Date of Birth:	% Split:

III. Authorization

The beneficiary designation applies to all funding options (including life insurance) unless otherwise noted.

Participant Signature: ______________________________ **Date:** ______________

NOTE: Witness can NOT be a named beneficiary.

Witness Signature: ______________________________ **Date:** ______________

Witness Name: ____

City: ______________________________ State: ________ Zip: ________