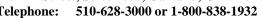


## SURVIVOR CONTINUANCE RECIPIENT'S **DESIGNATION OF BENEFICIARIES**

## ALAMEDA COUNTY EMPLOYEES' RETIREMENT ASSOCIATION

475 14th Street, Suite 1000, Oakland, CA 94612



EAV (510) 268-0574



Telephone: 510-028-5000 or 1-800-858-1	1932 FAX (510) 206-93	yvebsite: wv	ww.acera.org
Name: Social Security No			
Address:	City:	State:	Zip Code:
Home Phone No.: ()	Cell	Phone No.: ()	
Date of Birth:/	Sex: Male Female	÷	
Email Address:			
I hereby name the following be but not limited to any allowance earned applied:			
IF YOU ARE NAMING A MINOR, Receive and manage payments for the muse this format to name the beneficiary number at least 18 but not more than address and telephone number and the requirements of a guardian will be required distributed to the beneficiary at age 18.	ninor without court appoint ry: [Name of adult] as cu 25] under the California U minor's date of birth, socia neficiary without naming a	tment or court supervi- ustodian for [Name of Uniform Transfers to al security number, and a custodian, in which a	sion until an age you choose f minor] until age [choose of Minors Act. Use the adult's d relationship. Alternatively a case court appointment and
NOTE: To name different beneficiarie ACERA for that purpose. In addition, beneficiary. If you do not indicate a pero	, indicate the percentage of	of benefit (total should	d not exceed 100%) for each
Unless you provide otherwise, if you nat deceased you, ACERA shall pay surviving			rimary beneficiaries have pre-
PRIMARY BENEFICIARY:			
Name:	Percentaş	ge of Benefit:	
Address:		_	
City, State, Zip Code:			
Telephone Number: ()		· ·	
Cell Phone Number:			
Name:	Percentaş	Percentage of Benefit:	
Address:			
City, State, Zip Code:			
Telephone Number: ()	Email Ad	Email Address:	
Cell Phone Number:	Relationship:		

Relationship:

If no primary beneficiary survives you, we will pay these benefits to the contingent beneficiaries named below.

Unless you provide otherwise, if you name multiple contingent beneficiaries, in the event contingent beneficiaries have pre-deceased you, ACERA shall pay surviving contingent beneficiaries in equal shares.

CONTINGENT BENEFICIARY:			
Name:	Percentage of Benefit:		
Address:	Date of Birth:		
City, State, Zip Code:	Social Security No.:		
Telephone Number: ()	Email Address:		
Cell Phone Number:	Relationship:		
Name:	Percentage of Benefit:		
Address:	_ Date of Birth:		
City, State, Zip Code:	Social Security No.:		
Telephone Number: ()	Email Address:		
Cell Phone Number:	Relationship:		
Please sign below:			
I hereby confirm the beneficiary designations shown on this form. I understand this form is not effective (binding on ACERA) until it is received by ACERA in its office.  I hereby grant and authorize ACERA to reduce the death benefit payable to my designated beneficiary by any and all amounts owed to ACERA upon my death.			
Signature:	Date:		
Dutc			

Revised: 05/07/2012

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