SURVIVOR CONTINUANCE RECIPIENT'S DESIGNATION OF BENEFICIARIES

ALAMEDA COUNTY EMPLOYEES' RETIREMENT ASSOCIATION
475 14th Street, Suite 1000, Oakland, CA 94612
Telephone: 510-628-3000 or 1-800-838-1932 FAX (510) 268-9574 Website: www.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 beneficiaries to receive any benefits payable at the time of my death, including but not limited to any allowance earned but not yet paid and any refund of prepaid health insurance premiums not yet applied:

IF YOU ARE NAMING A MINOR, READ THIS: If a beneficiary is a minor and you wish to name an adult to receive and manage payments for the minor without court appointment or court supervision until an age you choose, use this format to name the beneficiary: *[Name of adult] as custodian for [Name of minor] until age [choose a number at least 18 but not more than 25] under the California Uniform Transfers to Minors Act.* Use the adult's address and telephone number and the minor's date of birth, social security number, and relationship. Alternatively, you may simply name the minor as beneficiary without naming a custodian, in which a case court appointment and supervision of a guardian will be required before any payments can be distributed; otherwise, all funds will be distributed to the beneficiary at age 18.

NOTE: To name different beneficiaries for different benefits, use a separate beneficiary form to be provided by ACERA for that purpose. In addition, indicate the percentage of benefit (total should not exceed 100%) for each beneficiary. If you do not indicate a percentage, payment will be divided in equal shares to the named beneficiaries.

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

PRIMARY 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: _____

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: _____

Revised: 05/07/2012

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