



Written Nomination of Beneficiary Final Payment Upon Death

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SECTION 1: RE	TIREE INFOR	RMAT	TION						
FIRST NAME:		MI:	LAST NAME:	SEX:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:			
NEW ADDRESS?	□ YES □ I	NO		I		<u>.</u>			
MAILING ADDRESS:				CITY:		STATE:	ZIP CODE:		
HOME ADDRESS:			CITY:	CITY:		ZIP CODE:			
HOME PHONE:	CELL PHONE: EMAIL ADDRESS:								
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SECTION 2: BE		NFO	RMATION						
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	HOME ADDRES	e,		CITY:		STATE:	ZIP CODE:		
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HOME PHONE: CELL PHONE:		E-MAIL ADDRESS:			RELATIONSHIP:				
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BENFICIARY #2	□ PRIMA	ARY	□ CONTINGENT						
FIRST NAME:		MI:	LAST NAME:	SEX:	DATE OF BIRTH:	SOCIAL S	ECURITY NUMBER:		
BENEFIT PERCENT:	MAILING ADDRI	ESS:		CITY:		STATE:	ZIP CODE:		
	HOME ADDRES	S:		CITY:		STATE:	ZIP CODE:		
HOME PHONE:	OME PHONE: CELL PHONE: E-MAIL ADDRESS		E-MAIL ADDRESS:				RELATIONSHIP:		
BENFICIARY #3	□ PRIMA	1DV	□ CONTINGENT						
FIRST NAME:	L PRIMA	MI:	LAST NAME:	SEX:	DATE OF BIRTH:	SOCIAL S	ECURITY NUMBER:		
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BENEFIT PERCENT:	MAILING ADDRI	FSS:		CITY:		STATE:	ZIP CODE:		
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	HOME ADDRES	S·		CITY:		STATE:	ZIP CODE:		
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HOME PHONE:	CELL PHONE:		E-MAIL ADDRESS:			RELATION	 		
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RETIREE INFOR	WATION - P				DATE OF 5:55	000:::		
FIRST NAME:		MI:	LAST NAME:		DATE OF BIRTH:	SOCIAL SECURITY NUMBER:		
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BENFICIARY #4	□ PRIMA	RY	□ CONTINGENT	_				
FIRST NAME:		MI:	LAST NAME: SE		DATE OF BIRTH: SOCIAL		SECURITY NUMBER:	
BENEFIT PERCENT:	MAILING ADDRESS:			CITY:		STATE:	ZIP CODE:	
	HOME ADDRESS:			CITY:		STATE:	ZIP CODE:	
OME PHONE: CELL PHONE:			E-MAIL ADDRESS:		RELATIONSHIP:			
BENFICIARY #5		RY						
FIRST NAME:		MI:	LAST NAME:	SEX:	DATE OF BIRTH:	SOCIAL S	ECURITY NUMBER:	
BENEFIT PERCENT:	MAILING ADDRE	SS:		CITY:	CITY:		ZIP CODE:	
	HOME ADDRESS	S :		CITY:		STATE:	ZIP CODE:	
HOME PHONE:	CELL PHONE:		E-MAIL ADDRESS:			RELATIONSHIP:		
SECTION 3: RE	QUIRED SIG	NAT	URES					
event of my dea	ath and upon re to Stanislaus C	eceip	d beneficiary to receive a retu t of a photocopy of the final o Employees' Retirement Asso	certified deat	h certificate. I als	so acknov	vledge that any	
This revokes any	and all previo	us b	eneficiaries nominated for t	his benefit.				
Applicant Signature:			Printed Name:			Date:		
Witness Signature: (other than named beneficiary)		Printed Name:			Date:			