



# Beneficiary Designation Governmental 457(b) Plan

Use black or blue ink when completing this form. For questions regarding this form, contact Service Provider at 1-800-701-8255.

## 98215-01 City of Torrance Deferred Compensation Plan A

A Participant Information				
Social Security Number		Account Extension		<i>Account extension identifies funds transferred to a beneficiary due to death, alternate payee due to divorce or a participant with multiple accounts.</i>
Last Name		First Name	M.I.	Date of Birth ( ) / ( ) / ( )
Street Address				Personal Phone Number ( ) ( ) ( ) ( ) ( ) ( )
City		State	Zip Code	Work Phone Number
Email Address				<input type="checkbox"/> Married <input type="checkbox"/> Unmarried
Division/Payroll Center				Employee Number

B Primary Beneficiary Designation (Attach an additional sheet to name additional beneficiaries.)				
If I am married, my Plan requires my spouse as primary beneficiary for 100% or my spouse consents to my beneficiary designation.				
%		/ /		
% of Account Balance	Primary Beneficiary Name	Relationship	Social Security Number	Date of Birth
Street Address		City	State	Zip Code
%		/ /		
% of Account Balance	Primary Beneficiary Name	Relationship	Social Security Number	Date of Birth
Street Address		City	State	Zip Code
%		/ /		
% of Account Balance	Primary Beneficiary Name	Relationship	Social Security Number	Date of Birth
Street Address		City	State	Zip Code

Contingent Beneficiary Designation				
%		/ /		
% of Account Balance	Contingent Beneficiary Name	Relationship	Social Security Number	Date of Birth
Street Address		City	State	Zip Code
%		/ /		
% of Account Balance	Contingent Beneficiary Name	Relationship	Social Security Number	Date of Birth
Street Address		City	State	Zip Code
%		/ /		
% of Account Balance	Contingent Beneficiary Name	Relationship	Social Security Number	Date of Birth
Street Address		City	State	Zip Code

C Signatures and Consent
<p><b>Participant Consent</b></p> <p>I have completed, understand and agree to all pages of this Beneficiary Designation form. Subject to and in accordance with the terms of the Plan, I am making the above beneficiary designations for my vested account in the event of my death. If I have more than one primary beneficiary, the account will be divided as specified. If a primary beneficiary predeceases me, his or her benefit will be allocated to the surviving primary beneficiaries. Contingent beneficiaries will receive a benefit only if there is no surviving primary beneficiary, as specified. If a contingent beneficiary predeceases me, his or her benefit will be allocated to the surviving contingent beneficiaries. If I fail to designate beneficiaries, amounts will be paid pursuant to the terms of the Plan or applicable law. This designation is effective upon execution and delivery to Service Provider. If any information is missing, additional information may be required prior to recording my designation.</p> <p>This designation supersedes all prior designations. Beneficiaries will share equally if percentages are not provided and any amounts unpaid upon death will be divided equally. <b>Primary and contingent beneficiaries must separately total 100% in whole percentages.</b></p>



Last Name

First Name

M.I.

Social Security Number

Number

I understand that Service Provider is required to comply with the regulations and requirements of the Office of Foreign Assets Control, Department of the Treasury ("OFAC"). As a result, Service Provider cannot conduct business with persons in a blocked country or any person designated by OFAC as a specially designated national or blocked person. For more information, please access the OFAC Web site at: <http://www.treasury.gov/about/organizational-structure/offices/Pages/Office-of-Foreign-Assets-Control.aspx>.

Important Notice: If I am married and I elect a primary beneficiary other than my spouse or in addition to my spouse, my spouse must consent by signing the Spousal Consent section of this form.

Any person who presents false or fraudulent information is subject to criminal and civil penalties.

Participant Signature \_\_\_\_\_

Date (Required) \_\_\_\_\_

**Spousal Consent****Dates of the participant's spouse signature and notarization must match.**

I, (name of spouse) \_\_\_\_\_, the current spouse of the participant, hereby voluntarily consent to the participant's primary beneficiary designation above and understand its effect. I understand that by providing such consent I am waiving my right to receive either all (if I am not designated as a primary beneficiary) or a percentage (if I and another person are designated as primary beneficiaries) of the participant's vested account which would otherwise be payable to me upon the participant's death. I understand that my consent is irrevocable unless my spouse changes beneficiary designation, or designates me as a primary beneficiary to receive his or her entire vested account balance.

Spouse Signature \_\_\_\_\_

Date (Required) \_\_\_\_\_

If I live in California and my notary is required to use the state notary form, the following items must be completed by the notary on the state notary form: the title of the form I am completing, the plan name, the plan number, the document date, the participant's name and participant spouse's name. The notary forms not containing this information will be rejected and it will delay this request.

**Witness of Spouse's Signature**

*The spouse's signature must be witnessed by a Notary Public.*

Statement of Notary

**NOTE: Notary seal must be visible.**

State of \_\_\_\_\_ ) The consent to this request was subscribed and sworn (*or affirmed*)  
to before me on this \_\_\_\_\_ day of \_\_\_\_\_, year \_\_\_\_\_, by  
)ss. (*name of spouse*) \_\_\_\_\_

County of \_\_\_\_\_ ) proved to me on the basis of satisfactory evidence to be the person who  
appeared before me, who affirmed that such consent represents his/her free  
and voluntary act.

**SEAL**

Notary Public Signature \_\_\_\_\_

My commission expires \_\_\_\_\_

**Authorized Plan Administrator/Trustee Signature**

I accept the information provided by the participant on this form.

Authorized Plan Administrator/Trustee Signature \_\_\_\_\_

Date (Required) \_\_\_\_\_

**D Mailing Instructions**

**Participant** forward to City of Torrance

**City of Torrance** forward to Service Provider

City of Torrance  
City Treasurer  
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Torrance, CA 90503

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