DESIGNATION OF BENEFICIARY FORM
PART-TIME NON-ELIGIBLE EMPLOYEES ONLY

- Use this form to designate your beneficiary for your Oakland County PTS account
- Please print in blue or black ink
- AFTER COMPLETING THIS FORM, SEND DIRECTLY TO ICMA - NO COUNTY SIGNATURE IS REQUIRED

ICMA Retirement Corp.
Attn: Workflow Management Team
P.O. Box 96220
Washington, D.C. 20090-6220

1 Participant Information
You must complete the information in this section

306351 (Employer Plan Number) | OAKLAND COUNTY PTS (Employer Plan Name) | MI (State) | _____/_____/_____ (Social Security Number)

(_____)_____ - _____ (Daytime Phone Number (with area code))

Male ☐ Female ☐

_____/_____/_____ (Date of Birth (MM/DD/YYYY))

_____
Name of Participant (Last, First, M.I.)

(_____)_____ - _____ (Home Phone Number (with area code))

☐ Married ☐ Single ☐ Widowed (Marital Status)

2 Beneficiary Designation

Primary Beneficiary(ies):

Name: _____ SSN:_____
Relationship to you:_____ % of Benefit:_____
Name: _____ SSN:_____
Relationship to you:_____ % of Benefit:_____
Name: _____ SSN:_____
Relationship to you:_____ % of Benefit:_____

Contingent Beneficiary(ies): Benefits will be paid to any named contingent beneficiary only if no primary beneficiary lives longer than you.

Name: _____ SSN: _____
Relationship to you:_____ % of Benefit: _____
Name: _____ SSN: _____
Relationship to you:_____ % of Benefit: _____
Name: _____ SSN:_____
Relationship to you:_____ % of Benefit:_____

3 Participant signature
Mail this form directly to ICMA-RC

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO MY KNOWLEDGE AND BELIEF.

_____ _____
Participant Signature Date

SEND THIS FORM DIRECTLY TO ICMA-RC

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P.O. Box 96220
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1-800-326-7060