



# EMPLOYEE BENEFICIARY CHANGE FORM

- Use this form to change your beneficiary for your Oakland Performance Retirement System account
- Please print in blue or black ink
- For enrollments, use the Employee Enrollment Form available from ICMA-RC or Oakland County
- AFTER COMPLETING THIS FORM, SEND DIRECTLY TO ICMA - NO COUNTY SIGNATURE IS REQUIRED

<b>1</b> <b>Participant Information</b> <i>You must complete the information in this section</i>	<table style="width:100%; border: none;"> <tr> <td style="width:25%; border-bottom: 1px solid black; text-align: center;">1 0 9 3 2 6</td> <td style="width:30%; border-bottom: 1px solid black; text-align: center;">OAKLAND COUNTY</td> <td style="width:10%; border-bottom: 1px solid black; text-align: center;">MI</td> <td style="width:35%; border-bottom: 1px solid black; text-align: center;">/ /</td> </tr> <tr> <td style="font-size: small;">Employer Plan Number</td> <td style="font-size: small;">Employer Plan Name</td> <td style="font-size: small;">State</td> <td style="font-size: small;">Social Security Number</td> </tr> <tr> <td style="border-bottom: 1px solid black; text-align: center;">( ) -</td> <td style="border-bottom: 1px solid black; text-align: center;">Male <input type="checkbox"/></td> <td colspan="2" style="border-bottom: 1px solid black; text-align: center;">/ /</td> </tr> <tr> <td style="font-size: small;">Daytime Phone Number with area code</td> <td style="font-size: small;">Female <input type="checkbox"/></td> <td colspan="2" style="font-size: small;">Date of birth (MM/DD/YY)</td> </tr> <tr> <td colspan="4" style="border-top: 1px solid black; padding-top: 5px;">Name of Participant (Last, First, M.I.)</td> </tr> </table>	1 0 9 3 2 6	OAKLAND COUNTY	MI	/ /	Employer Plan Number	Employer Plan Name	State	Social Security Number	( ) -	Male <input type="checkbox"/>	/ /		Daytime Phone Number with area code	Female <input type="checkbox"/>	Date of birth (MM/DD/YY)		Name of Participant (Last, First, M.I.)			
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<i>Complete only if information has changed</i>	<table style="width:100%; border: none;"> <tr> <td style="width:50%; border-bottom: 1px solid black; text-align: center;">( ) -</td> <td style="width:50%; text-align: center;"> <input type="checkbox"/> Married    <input type="checkbox"/> Single    <input type="checkbox"/> Widowed         </td> </tr> <tr> <td style="font-size: small;">Home phone number with area code)</td> <td style="font-size: small; text-align: center;">Marital Status</td> </tr> </table>	( ) -	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed	Home phone number with area code)	Marital Status																
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<b>2</b> <b>Beneficiary Designation</b>	<p><b>Primary Beneficiary(ies):</b></p> <p>Name: _____ SSN: _____</p> <p>Relationship to you: _____ % of Benefit: _____</p> <p>Name: _____ SSN: _____</p> <p>Relationship to you: _____ % of Benefit: _____</p> <p>Name: _____ SSN: _____</p> <p>Relationship to you: _____ % of Benefit: _____</p> <p><b>Contingent Beneficiary(ies):</b> Benefits will be paid to any named contingent beneficiary only if no primary beneficiary lives longer than you.</p> <p>Name: _____ SSN: _____</p> <p>Relationship to you: _____ % of Benefit: _____</p> <p>Name: _____ SSN: _____</p> <p>Relationship to you: _____ % of Benefit: _____</p> <p>Name: _____ SSN: _____</p> <p>Relationship to you: _____ % of Benefit: _____</p>																				
<b>3</b> <b>Participant signature</b> <i>Mail this form directly to ICMA-RC</i>	<p><b>I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO MY KNOWLEDGE AND BELIEF.</b></p> <p style="text-align: center;">_____</p> <p style="display: flex; justify-content: space-between;"> <span>Participant Signature</span> <span>Date</span> </p>																				

## SEND THIS FORM DIRECTLY TO ICMA-RC

ICMA Retirement Corporation  
 Attn: Workflow Management Team  
 P. O. Box 96220  
 Washington, DC 20090-6220  
 1-800-326-7060