CONFEDERATED TRIBES OF COLVILLE RESERVATION
RETIREMENT PLAN
BENEFICIARY DESIGNATION FORM

Name:______________________________ Social Security Number:______________________

Address:______________________________ Date of Birth:______________________

City, State Zip:______________________________ Date of Hire:______________________

Division:______________________________ Home:______________ Work:______________

Pursuant to the provisions of the Plan, I hereby revoke any prior designation and do hereby direct that, upon my death, any benefit payable with respect to me under the Plan shall be paid to the primary beneficiary named below as my **primary beneficiary**. If I should die and no primary beneficiary is alive to receive any benefit payable from the Plan, I hereby direct that such benefit shall be paid to the **contingent beneficiary** named below.

NOTE: If you are married, you **must** designate your spouse as your only **primary beneficiary** unless your spouse consents in writing in the space below. If you are single and marry at a later date, your spouse will automatically become your only primary beneficiary. If you do not want your spouse to be your only primary beneficiary, you and your spouse may designate a different primary beneficiary.

Primary Beneficiary

Full Name ______________________________

SS# ______________ Relationship ______________

Address ______________________________

____

Contingent Beneficiary

Full Name ______________________________

SS# ______________ Relationship ______________

Address ______________________________

____

(Attach additional sheets of paper if more space is required.)

I understand that I have the right to change or revoke the primary beneficiary designation with the approval of my spouse subject to receipt by the Plan Administrator of my written designation prior to my death. I may change or revoke my contingent beneficiary at any time subject to receipt by the Administrator. If my primary and contingent beneficiaries fail to survive me, I hereby authorize the Administrator to provide for payment of any Death Benefits as directed by the Plan. This Beneficiary Designation shall become effective without further notice upon receipt by the Administrator and is made subject to all of the terms and conditions of the Confederated Tribes of Colville Reservation Retirement Plan.

Your Signature ______________________________ **Date** ______________________

Witness Signature ______________________________ **Date** ______________________

If you are single, please check the box to the right and do not complete the rest of this form. ☐

If you are married and your spouse is your only primary beneficiary, please check the box to the right and do not complete the rest of this form. **Otherwise, your spouse must sign below and your spouse's signature must be witnessed by a Notary Public.** ☐

I hereby acknowledge that my spouse has designated a Primary Beneficiary in place of me. I understand that by consenting to this designation, I am foregoing both present and future rights to these benefits if my spouse dies. I further understand my consent is irrevocable unless my spouse revokes the Primary Beneficiary designation on this form. By my signature below, I approve the designation made.

SPOUSE'S SIGNATURE ______________________________ **DATE** ______________________

STATE OF ______________________) COUNTY OF ______________________)

On this __________ day of ______________________, 20__________, before me, the undersigned Notary Public, personally appeared , known to me to be the person whose signature is subscribed to the foregoing Designation of Beneficiary document, who acknowledged that he/she executed the same for the purposes therein contained.

WITNESS my hand and official seal.

____
Notary Public

Please return the completed form to the Benefits Office or Human Resources Department at your Division

<u>Instructions for Division:</u> (1) Review form to make sure that it has been completed correctly, (2) Retain the original form in the participant's Personnel Folder, (3) Provide a copy to the CCT Benefits Office, and (4) Mail a copy to TM&A.