StanCERA | Stanislaus County Employees' Retirement Association

Written Nomination of Beneficiary
Final Payment Upon Death

Type or print in ink.

SECTION 1: RETIREE INFORMATION

FIRST NAME:	MI:	LAST NAME:	SEX:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:

NEW ADDRESS? ☐ **YES** ☐ **NO**

MAILING ADDRESS:	CITY:	STATE:	ZIP CODE:
HOME ADDRESS:	**CITY:**	**STATE:**	**ZIP CODE:**

HOME PHONE:	CELL PHONE:	EMAIL ADDRESS:

SECTION 2: BENEFICIARY INFORMATION

PRIMARY BENEFICIARY

FIRST NAME:	MI:	LAST NAME:	SEX:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:

BENEFIT PERCENT:	MAILING ADDRESS:	CITY:	STATE:	ZIP CODE:
	HOME ADDRESS:	**CITY:**	**STATE:**	**ZIP CODE:**

HOME PHONE:	CELL PHONE:	E-MAIL ADDRESS:	RELATIONSHIP:

BENFICIARY #2 ☐ ***PRIMARY*** ☐ ***CONTINGENT***

FIRST NAME:	MI:	LAST NAME:	SEX:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:

BENEFIT PERCENT:	MAILING ADDRESS:	CITY:	STATE:	ZIP CODE:
	HOME ADDRESS:	**CITY:**	**STATE:**	**ZIP CODE:**

HOME PHONE:	CELL PHONE:	E-MAIL ADDRESS:	RELATIONSHIP:

BENFICIARY #3 ☐ ***PRIMARY*** ☐ ***CONTINGENT***

FIRST NAME:	MI:	LAST NAME:	SEX:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:

BENEFIT PERCENT:	MAILING ADDRESS:	CITY:	STATE:	ZIP CODE:
	HOME ADDRESS:	**CITY:**	**STATE:**	**ZIP CODE:**

HOME PHONE:	CELL PHONE:	E-MAIL ADDRESS:	RELATIONSHIP:

RETIREE INFORMATION – PAGE 2

FIRST NAME:	MI:	LAST NAME:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:

BENFICIARY #4 ☐ *PRIMARY* ☐ *CONTINGENT*					
FIRST NAME:	**MI:**	**LAST NAME:**	**SEX:**	**DATE OF BIRTH:**	**SOCIAL SECURITY NUMBER:**

BENEFIT PERCENT:	MAILING ADDRESS:	CITY:	STATE:	ZIP CODE:
	HOME ADDRESS:	**CITY:**	**STATE:**	**ZIP CODE:**

HOME PHONE:	CELL PHONE:	E-MAIL ADDRESS:	RELATIONSHIP:

BENFICIARY #5 ☐ *PRIMARY* ☐ *CONTINGENT*					
FIRST NAME:	**MI:**	**LAST NAME:**	**SEX:**	**DATE OF BIRTH:**	**SOCIAL SECURITY NUMBER:**

BENEFIT PERCENT:	MAILING ADDRESS:	CITY:	STATE:	ZIP CODE:
	HOME ADDRESS:	**CITY:**	**STATE:**	**ZIP CODE:**

HOME PHONE:	CELL PHONE:	E-MAIL ADDRESS:	RELATIONSHIP:

SECTION 3: REQUIRED SIGNATURES

I hereby nominate the above-named beneficiary to receive a return of any member contributions, still on deposit, in the event of my death and upon receipt of a photocopy of the final certified death certificate. I also acknowledge that any amounts owed to Stanislaus County Employees' Retirement Association, upon my death, which are not recoverable, will be deducted from this benefit.

This revokes any and all previous beneficiaries nominated for this benefit.

Applicant Signature: _____ **Printed Name:** _____ **Date:** _____

Witness Signature: _____ **Printed Name:** _____ **Date:** _____
(other than named beneficiary)