Beneficiary Designation Form

Valley Medical Group, P.C.
401(k) Plan

Plan Number: 860160

Request Type

☐ **Initial Designation** ☐ **Change to Designation**

Participant Information

Name (first, middle initial, last)	Social Security Number - -	☐ Married ☐ Single

Beneficiary Information

Subject to the terms of my Employer's Plan, I request that any sum becoming due upon my death be payable to the beneficiary(ies) designated below. I understand this designation shall revoke all prior beneficiary designations made by me under my Employer's Plan. *(All designations must be in whole percentages. Total percentage must equal 100% for Primary Beneficiary and 100% for Contingent Beneficiary, if designated.)*

1. Beneficiary Name (complete legal name required)	Relationship ☒ Primary Beneficiary	Percentage
Address and Phone #	Social Security Number/TIN	Date of Birth (mm/dd/yyyy)
2. Beneficiary Name (complete legal name required)	Relationship ☐ Primary Beneficiary ☐ Contingent Beneficiary	Percentage
Address and Phone #	Social Security Number/TIN	Date of Birth (mm/dd/yyyy)
3. Beneficiary Name (complete legal name required)	Relationship ☐ Primary Beneficiary ☐ Contingent Beneficiary	Percentage
Address and Phone #	Social Security Number/TIN	Date of Birth (mm/dd/yyyy)
4. Beneficiary Name (complete legal name required)	Relationship ☐ Primary Beneficiary ☐ Contingent Beneficiary	Percentage
Address and Phone #	Social Security Number/TIN	Date of Birth (mm/dd/yyyy)
5. Beneficiary Name (complete legal name required)	Relationship ☐ Primary Beneficiary ☐ Contingent Beneficiary	Percentage
Address and Phone #	Social Security Number/TIN	Date of Birth (mm/dd/yyyy)
6. Beneficiary Name (complete legal name required)	Relationship ☐ Primary Beneficiary ☐ Contingent Beneficiary	Percentage
Address and Phone #	Social Security Number/TIN	Date of Birth (mm/dd/yyyy)

Unless otherwise requested:

1. If more than one beneficiary is designated, payment will be made in equal shares to the primary beneficiaries who survive the participant or annuitant or, if none survives the participant or annuitant, in equal shares to the contingent beneficiaries who survive the participant or annuitant.
2. If no beneficiary survives the participant or annuitant, payment will be made to the executors or administrators of the estate of the participant or annuitant.

Please complete this form and return it to your Plan Administrator.

Beneficiary Designation Form (continued)

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Name (first, middle initial, last)	Social Security Number - -

Certification

- ☐ I am not married at the time I am making this beneficiary designation. I understand that if I later marry, I must submit a new designation naming my spouse as beneficiary, unless he or she agrees in writing to a different beneficiary.
- ☐ I am married and have named my spouse as sole/primary beneficiary.
- ☐ I am married and have named someone other than my spouse as sole/primary beneficiary and my spouse agrees to such designation (spouse must also sign below in the presence of a Notary Public or Plan Representative).

Trust Certification

By signing below, I certify that:

A. Name of Trust or Trust instrument _____

B. The Trust or Trust instrument identified above, is in full force and effect and is a valid Trust or Trust instrument under the laws of the State or Commonwealth of

_____

C. The Trust is irrevocable, or will become irrevocable, upon my death.

D. All beneficiaries are individuals and are identifiable from the terms of the Trust.

In the event that any of the information provided above changes, I will provide Voya Financial® with the changes, within a reasonable period of time.

By designating a Trust, additional documentation and/or certification may be required.

Signatures

I hereby certify under the pains and penalties of perjury that information I furnished herein is true, accurate and complete.

Participant's Signature	Signed in City/Town and State	Date (mm/dd/yyyy)
Witness' Name	Witness' Signature	

(Account Holder's signature must be witnessed. Witness must be a person of legal age, and someone other than spouse or designated beneficiary.)

Please complete this form and return it to your Plan Administrator.

Spousal Consent

This is to certify that I am the spouse of the above named participant and agree with the beneficiary designation. I understand that the above designation specifies the only person(s) who will receive any death benefits payable in the event of death of the participant.

Spouse's Name	Social Security Number - -
Spouse's Signature	Date (mm/dd/yyyy)

On this the _____ day of _____, in the year of _____ before me, _____ (Notary) the undersigned officer, personally appeared _____ (spouse) known to me (or satisfactorily proven) to be the person whose name is subscribed to within the instrument and acknowledged that he/she executed the same for the purposes therein contained.

In Witness Whereof, I hereunto set my hand

_____
Notary Public

(SEAL)

My Commission Expires _____

OR

AUTHORIZED PLAN REPRESENTATIVE

The above spousal consent was signed by the Spouse in my presence.

Authorized Plan Representative Name (Please print.) _____

Authorized Plan Representative Signature _____ Date (mm/dd/yyyy) _____

Please complete this form and return it to your Plan Administrator.