



SUFFOLK COUNTY MUNICIPAL EMPLOYEES BENEFIT FUND  
DESIGNATION OF BENEFICIARY FORM  
\$1000 SURVIVORS BENEFIT

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Please PRINT: Submit the original and one copy of this form to your payroll representative. Retain one copy for your records.

NAME: \_\_\_\_\_ SSN: \_\_\_\_\_  
HOME ADDRESS: \_\_\_\_\_ FORMER NAME: \_\_\_\_\_  
CITY, STATE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

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I hereby name the following Beneficiary(s) to receive any ordinary death benefit, payable on my behalf. I reserve the right to change the designation at any time.

1. NAME: \_\_\_\_\_ SSN \_\_\_\_\_  
HOME ADDRESS: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
CITY, STATE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

2. NAME: \_\_\_\_\_ SSN \_\_\_\_\_  
HOME ADDRESS: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
CITY, STATE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

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CONTINGENT BENEFICIARY

If the above named beneficiary predeceases me, any ordinary death benefit payable on my behalf shall be paid to the following. I reserve the right to change my designation at any time.

NAME: \_\_\_\_\_ SSN \_\_\_\_\_  
HOME ADDRESS: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
CITY, STATE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

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\_\_\_\_\_  
MEMBER'S SIGNATURE

\_\_\_\_\_  
DATE