



SUFFOLK COUNTY MUNICIPAL EMPLOYEES BENEFIT FUND
DESIGNATION OF BENEFICIARY FORM

\$10,000 BEREAVEMENT BENEFIT

Submit the original form to your payroll representative. Retain one copy for your records.

Please PRINT clearly:

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

MEMBER'S SIGNATURE

DATE

I hereby name the following BENEFICIARY(S) to receive the Bereavement Benefit, payable on my behalf. I reserve the right to change the designation at any time. If the named beneficiary predeceases me, this benefit payable on my behalf shall be paid to the CONTINGENT beneficiary listed below. I reserve the right to change my designation at any time. Social security numbers of any listed beneficiary must be provided.

1. NAME: \_\_\_\_\_ SSN: \_\_\_\_\_
HOME ADDRESS: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ BENEFICIARY [ ]
CONTINGENT [ ]
(Check Only One)
CITY, STATE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

2. NAME: \_\_\_\_\_ SSN: \_\_\_\_\_
HOME ADDRESS: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ BENEFICIARY [ ]
CONTINGENT [ ]
(Check Only One)
CITY, STATE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

3. NAME: \_\_\_\_\_ SSN: \_\_\_\_\_
HOME ADDRESS: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ BENEFICIARY [ ]
CONTINGENT [ ]
(Check Only One)
CITY, STATE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

4. NAME: \_\_\_\_\_ SSN: \_\_\_\_\_
HOME ADDRESS: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ BENEFICIARY [ ]
CONTINGENT [ ]
(Check Only One)
CITY, STATE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_