

# Optional Benefits Beneficiary Instructions

This form names the people you want to receive Supplemental Life, Accidental Death and Dismemberment, or Survivor insurances you may have elected in the event of your death. It may also be used to change those names at any time. **You are responsible for this form being received by the Division of Retirement and Benefits. Bring or mail this completed form directly to this office.**

**PLEASE NOTE: To designate beneficiaries for your Alaska Supplemental Annuity Plan (SBS-AP) account, you will need to complete a separate form designed by Great-West Retirement Services for your 401(a) plan. Call (800) 232-0859 or visit akdrb.com for the SBS-AP beneficiary form.**

## SECTION I: PERSONAL DATA

Complete this section each time you use this form.

## SECTION II: BENEFICIARY DESIGNATION

This section has space for up to five beneficiaries. If necessary, attach additional forms. This section must be completed listing all intended beneficiaries each time this form is used.

8. – 15. Enter the beneficiary's name, relationship to you, social security number, and address.
16. Indicate which benefits this beneficiary should receive if you die. Only check those programs in which you have enrolled.
17. Indicate whether this beneficiary is primary or contingent. Primary beneficiaries receive the benefit first if you die. Contingent beneficiaries receive the benefit if the primary beneficiary has died.
18. Indicate the percentage of the benefits that you would like this beneficiary to receive. The total percentage given to primary beneficiaries must equal 100%. The total percentage given to contingent beneficiaries must equal 100%.
19. – 62. List as many beneficiaries as you like, following the instructions for the first beneficiary in #8 through #18 above.

### EXAMPLES

Jane Doe is married with no children. She wishes her husband to receive this benefit if she dies:

BENEFICIARY LAST NAME <b>Doe</b>	FIRST NAME <b>John</b>	M.I. <b>K.</b>	RELATIONSHIP <b>Husband</b>	SOCIAL SECURITY NUMBER <b>123-45-6789</b>
MAILING ADDRESS <b>1000 Any Street</b>		CITY AND STATE <b>Anytown, AK</b>		ZIP CODE <b>99999</b>
I WANT THIS BENEFICIARY TO RECEIVE THE FOLLOWING BENEFITS IF I DIE: <input checked="" type="checkbox"/> LIFE <input type="checkbox"/> AD&D <input type="checkbox"/> SURVIVOR		I WANT THIS BENEFICIARY TO BE: <input checked="" type="checkbox"/> PRIMARY <input type="checkbox"/> CONTINGENT		I WANT THIS BENEFICIARY TO RECEIVE: <b>100%</b>

Fred Smith is not married and has two children. He has enrolled in life insurance and Accidental Death and Dismemberment (AD&D). He wishes his children to share equally if he dies:

BENEFICIARY LAST NAME <b>Smith</b>	FIRST NAME <b>Jane</b>	M.I. <b>K.</b>	RELATIONSHIP <b>Daughter</b>	SOCIAL SECURITY NUMBER <b>234-56-7891</b>
MAILING ADDRESS <b>1000 "E" Street</b>		CITY AND STATE <b>Anytown, AK</b>		ZIP CODE <b>99999</b>
I WANT THIS BENEFICIARY TO RECEIVE THE FOLLOWING BENEFITS IF I DIE: <input checked="" type="checkbox"/> LIFE <input checked="" type="checkbox"/> AD&D <input type="checkbox"/> SURVIVOR		I WANT THIS BENEFICIARY TO BE: <input checked="" type="checkbox"/> PRIMARY <input type="checkbox"/> CONTINGENT		I WANT THIS BENEFICIARY TO RECEIVE: <b>50%</b>
BENEFICIARY LAST NAME <b>Smith</b>	FIRST NAME <b>John</b>	M.I. <b>K.</b>	RELATIONSHIP <b>Son</b>	SOCIAL SECURITY NUMBER <b>345-67-8910</b>
MAILING ADDRESS <b>1000 "B" Street</b>		CITY AND STATE <b>Anytown, AK</b>		ZIP CODE <b>99999</b>
I WANT THIS BENEFICIARY TO RECEIVE THE FOLLOWING BENEFITS IF I DIE: <input checked="" type="checkbox"/> LIFE <input checked="" type="checkbox"/> AD&D <input type="checkbox"/> SURVIVOR		I WANT THIS BENEFICIARY TO BE: <input checked="" type="checkbox"/> PRIMARY <input type="checkbox"/> CONTINGENT		I WANT THIS BENEFICIARY TO RECEIVE: <b>50%</b>

## SECTION III: SIGNATURE

This form must be signed.



# Optional Benefits Beneficiary (Life, AD&D, Survivor)

FOR OFFICE USE ONLY

**Toll-Free: (800) 821-2251**  
**alaska.gov/drb**

Division of Retirement and Benefits  
P.O. Box 110203  
Juneau, Alaska 99811-0203

**Juneau: (907) 465-4460**  
TDD: (907) 465-2805  
FAX: (907) 465-3086



### SECTION I: PERSONAL DATA

PLEASE TYPE OR PRINT CLEARLY

EMPLOYEE LAST NAME	FIRST NAME	M.I.
RIN OR LAST 4 DIGITS OF SSN	HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER

### SECTION II: BENEFICIARY DESIGNATION

BENEFICIARY LAST NAME	FIRST NAME	M.I.	RELATIONSHIP	SOCIAL SECURITY NUMBER
MAILING ADDRESS			CITY AND STATE	ZIP CODE
I WANT THIS BENEFICIARY TO RECEIVE THE FOLLOWING BENEFITS IF I DIE: <input type="checkbox"/> LIFE <input type="checkbox"/> AD&D <input type="checkbox"/> SURVIVOR		I WANT THIS BENEFICIARY TO BE: <input type="checkbox"/> PRIMARY <input type="checkbox"/> CONTINGENT		I WANT THIS BENEFICIARY TO RECEIVE: %
BENEFICIARY LAST NAME	FIRST NAME	M.I.	RELATIONSHIP	SOCIAL SECURITY NUMBER
MAILING ADDRESS			CITY AND STATE	ZIP CODE
I WANT THIS BENEFICIARY TO RECEIVE THE FOLLOWING BENEFITS IF I DIE: <input type="checkbox"/> LIFE <input type="checkbox"/> AD&D <input type="checkbox"/> SURVIVOR		I WANT THIS BENEFICIARY TO BE: <input type="checkbox"/> PRIMARY <input type="checkbox"/> CONTINGENT		I WANT THIS BENEFICIARY TO RECEIVE: %
BENEFICIARY LAST NAME	FIRST NAME	M.I.	RELATIONSHIP	SOCIAL SECURITY NUMBER
MAILING ADDRESS			CITY AND STATE	ZIP CODE
I WANT THIS BENEFICIARY TO RECEIVE THE FOLLOWING BENEFITS IF I DIE: <input type="checkbox"/> LIFE <input type="checkbox"/> AD&D <input type="checkbox"/> SURVIVOR		I WANT THIS BENEFICIARY TO BE: <input type="checkbox"/> PRIMARY <input type="checkbox"/> CONTINGENT		I WANT THIS BENEFICIARY TO RECEIVE: %
BENEFICIARY LAST NAME	FIRST NAME	M.I.	RELATIONSHIP	SOCIAL SECURITY NUMBER
MAILING ADDRESS			CITY AND STATE	ZIP CODE
I WANT THIS BENEFICIARY TO RECEIVE THE FOLLOWING BENEFITS IF I DIE: <input type="checkbox"/> LIFE <input type="checkbox"/> AD&D <input type="checkbox"/> SURVIVOR		I WANT THIS BENEFICIARY TO BE: <input type="checkbox"/> PRIMARY <input type="checkbox"/> CONTINGENT		I WANT THIS BENEFICIARY TO RECEIVE: %
BENEFICIARY LAST NAME	FIRST NAME	M.I.	RELATIONSHIP	SOCIAL SECURITY NUMBER
MAILING ADDRESS			CITY AND STATE	ZIP CODE
I WANT THIS BENEFICIARY TO RECEIVE THE FOLLOWING BENEFITS IF I DIE: <input type="checkbox"/> LIFE <input type="checkbox"/> AD&D <input type="checkbox"/> SURVIVOR		I WANT THIS BENEFICIARY TO BE: <input type="checkbox"/> PRIMARY <input type="checkbox"/> CONTINGENT		I WANT THIS BENEFICIARY TO RECEIVE: %

### SECTION III: SIGNATURE

EMPLOYEE SIGNATURE	DATE
--------------------	------