STATE OF CONNECTICUT – COUNTY OF TOLLAND
INCORPORATED 1786

TOWN OF ELLINGTON

FINANCE OFFICE
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Deferred Compensation Plan 457

CHANGE IN BENEFICIARY

I wish to designate the following Beneficiary (or Beneficiaries) as indicated below.

Primary Beneficiary(ies): Person or persons who will receive benefits upon your death	
Name:	Date of Birth: ___ ___/___ ___/___ ___ ___ ___
Address:	Social Security No: __ __ __ - __ __ - __ __ __ __
Relationship:	% to be paid to Beneficiary: %
Name:	Date of Birth: ___ ___/___ ___/___ ___ ___ ___
Address:	Social Security No: __ __ __ - __ __ - __ __ __ __
Relationship:	% to be paid to Beneficiary: %
Name:	Date of Birth: ___ ___/___ ___/___ ___ ___ ___
Address:	Social Security No: __ __ __ - __ __ - __ __ __ __
Relationship:	% to be paid to Beneficiary: %
Total percentages must add up to 100%. If no percentages are indicated, the proceeds will be divided equally. If no Primary Beneficiary survives, proceeds will be paid to the Contingent Beneficiary(ies) listed below.	

Contingent Beneficiary(ies): Person or persons who will receive benefits upon your death if there is no surviving Primary Beneficiary.	
Name:	Date of Birth: ___ ___/___ ___/___ ___ ___ ___
Address:	Social Security No: __ __ __ - __ __ - __ __ __ __
Relationship:	% to be paid to Beneficiary: %
Name:	Date of Birth: ___ ___/___ ___/___ ___ ___ ___
Address:	Social Security No: __ __ __ - __ __ - __ __ __ __
Relationship:	% to be paid to Beneficiary: %
Name:	Date of Birth: ___ ___/___ ___/___ ___ ___ ___
Address:	Social Security No: __ __ __ - __ __ - __ __ __ __
Relationship:	% to be paid to Beneficiary: %

_____	_____	_____
Employee Printed Name	Employee Signature	Date