



# TOWN OF KILLINGLY

## FINANCE OFFICE

172 Main Street, Killingly, CT 06239  
Tel: 860-779-5339 Fax: 860-779-5363

## ENROLLMENT FORM

Authorization of Deductions from Earnings

Employee Name: \_\_\_\_\_

Current Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Male  Female

I hereby authorize my employer, the Town of Killingly, to deduct from my earnings such amounts as may be payable by me, from time to time, under the provisions of its retirement plan.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Date of Birth: \_\_\_\_\_

Date of Hire: \_\_\_\_\_



# TOWN OF KILLINGLY

## Beneficiary Designation

### A. Participant Data

First Name:	MI:	Last Name:	Social Security Number: ____ - ____ - ____	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single
Address:		City:	State:	Zip:

### B. Beneficiary Designation

First Name:	MI:	Last Name:	Date of Birth: __/__/____	Social Security Number: ____ - ____ - ____
Address:		City:	State:	Zip Code:
Relationship to Participant				

and to be shared equally with  otherwise

First Name:	MI:	Last Name:	Date of Birth: __/__/____	Social Security Number: ____ - ____ - ____
Address:		City:	State:	Zip Code:
Relationship to Participant				

and to be shared equally with  otherwise

First Name:	MI:	Last Name:	Date of Birth: __/__/____	Social Security Number: ____ - ____ - ____
Address:		City:	State:	Zip Code:
Relationship to Participant				

and to be shared equally with  otherwise

First Name:	MI:	Last Name:	Date of Birth: __/__/____	Social Security Number: ____ - ____ - ____
Address:		City:	State:	Zip Code:
Relationship to Participant				

### C. Participant Certification

I hereby revoke any and all prior beneficiary designation and I understand any payment payable to my above designated beneficiary(ies) after my death will be governed by the terms of the Plan.	
Participant Signature: _____	Date: ____/____/____



# TOWN OF KILLINGLY

# Beneficiary Designation

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

## D. Spousal Consent

Federal law requires that, upon the death of a vested, married participant, certain lifetime survivor benefits are payable to the spouse, unless such benefits are properly waived. The spouse must consent to the waiver of survivor benefits coverage. Also, if such coverage is waived and the Plan provides any other death benefit, the following rules apply:

- The spouse must be the sole primary beneficiary for such other death benefit, unless the spouse consents to another person as primary beneficiary; and
- If the spouse consents to another person as primary beneficiary, no changes can be made to that designation, unless the spouse either consents to such change or the change makes the spouse the sole primary beneficiary.

Accordingly, the statement below must be signed by the participant's spouse and witnessed by a plan representative or notary public before a beneficiary designation can be accepted when:

- (A) Qualified Pre-retirement Survivor Annuity coverage has been waived and the spouse has not been named sole primary beneficiary;
- (B) Qualified Post-retirement Joint and Survivor Annuity coverage has been waived and the spouse has not been named sole primary beneficiary; or
- (C) A change is being made to a previous designation to which the spouse had consented, but the Spouse is not being named sole primary beneficiary as a result of the change.

I have examined the beneficiary designation made by my spouse dated \_\_\_\_ / \_\_\_\_ / \_\_\_\_ and I consent to it. I understand that upon my spouse's death, the named beneficiary(ies) will receive the benefits payable in accordance with the Plan, including benefits to which I would otherwise be entitled. I understand that depending on the provisions of the Plan that I may not withdraw my consent to the designation. However, a new designation may be completed by my spouse and myself.

Spouse's Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Must Be Witnessed By A Notary Public OR Authorized Plan Representative

### Notary Public Information:

On this \_\_\_\_\_ day of \_\_\_\_\_, the year \_\_\_\_\_, before me personally appeared \_\_\_\_\_ (name of spouse) who executed the foregoing statement and acknowledge that he or she executed the same as a free act and deed.

Notary Seal/Stamp

My notary commission expires \_\_\_\_\_ with the state of \_\_\_\_\_.

Notary Public Signature: \_\_\_\_\_

## E. Plan Administrator Authorization

I certify that the above information is accurate, and is in accordance with the terms of the Plan.

Authorized Plan Representative Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_