Suffolk County Public Employees Deferred Compensation Plan
Designation of Beneficiary Form

Under the stipulations of the State of New York Model Deferred Compensation Plan, only plan participants and spousal beneficiaries are allowed to designate beneficiaries.

(Check One) ☐ Plan participant ☐ Spousal beneficiary

Participant Information
(Please print clearly)

Last Name _____ First _____ M.I. _____ Social Security Number _____

Present Marital Status
(Check one)

☐ Single ☐ Married ☐ Domestic Partner

Beneficiary Designation

I, the undersigned, hereby elect that upon my death the following person(s) shall be my primary and secondary beneficiary(ies) under the plan:

Primary Beneficiary(ies)

1)

Last Name _____ First _____ M.I. _____
Social Security Number _____
Street Address _____
City _____ State _____ ZIP Code _____
Birth Date _____ Relationship _____
Percent _____

2)

Last Name _____ First _____ M.I. _____
Social Security Number _____
Street Address _____
City _____ State _____ ZIP Code _____
Birth Date _____ Relationship _____
Percent _____

If you name more than one primary beneficiary but do not specify a percentage for each, your account will be divided equally among the primary beneficiaries who survive you. Check here if you have more than two primary beneficiaries and have used the space on the next page. ☐

Secondary Beneficiary(ies)

In the event the primary beneficiary(ies) is/are not living, I designate the following person(s) as my beneficiary(ies):

1)

Last Name _____ First _____ M.I. _____
Social Security Number _____
Street Address _____
City _____ State _____ ZIP Code _____
Birth Date _____ Relationship _____
Percent _____

2)

Last Name _____ First _____ M.I. _____
Social Security Number _____
Street Address _____
City _____ State _____ ZIP Code _____
Birth Date _____ Relationship _____
Percent _____

If you name more than one secondary beneficiary but do not specify a percentage for each, your account will be divided equally among the secondary beneficiaries who survive you. Check here if you have more than two secondary beneficiaries and have used the space on the next page. ☐

Participant's Signature

Any election I have made on this form revokes all prior designations with respect to this Plan.

Date _____ Participant's Signature _____

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Additional Primary Beneficiary(ies)

Last Name First M.I.	Last Name First M.I.
Social Security Number	Social Security Number
Street Address	Street Address
City State ZIP Code	City State ZIP Code
Birth Date Relationship	Birth Date Relationship
Percent	Percent

Additional Secondary Beneficiary(ies)

Last Name First M.I.	Last Name First M.I.
Social Security Number	Social Security Number
Street Address	Street Address
City State ZIP Code	City State ZIP Code
Birth Date Relationship	Birth Date Relationship
Percent	Percent

Please send completed form to:

T. Rowe Price Retirement Plan Services
Special Attn.: Forms Enclosed
P.O. Box 17215
Baltimore, MD 21297-1215