

**Chattanooga-Hamilton County Hospital Authority Pension Retirement Plan & Trust  
Beneficiary Designation**

Use this form to designate the person(s) to whom benefits under this plan, if any, are to be paid in the event of your death. If you are married or separated (but not divorced) at the time of your death, and if you wish to have your benefits paid to someone other than your spouse, your spouse must consent to the designation you have made herein. The law requires your spouse's written consent, notarized or signed by your spouse in the presence of a Plan representative, if you are naming someone other than your spouse as your primary beneficiary. If more than one primary or contingent beneficiary is named, please specify a percentage for each (attach additional page if necessary).

**PERSONAL INFORMATION (Please Print)**

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

Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street Address including apartment number

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse's Name \_\_\_\_\_  
Last First Middle

I hereby certify that I am not now married.

**PRIMARY BENEFICIARY INFORMATION (Please Print)**

I name the following as the primary beneficiary to receive any benefits payable at my death.

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street Address including apartment number

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**CONTINGENT BENEFICIARY INFORMATION (Please Print)**

If the primary beneficiary designated in Part II dies before I die, and if I fail prior to my death to name a substitute primary beneficiary, any benefit payable upon my death shall be paid to the following Contingent Beneficiary.

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street Address including apartment number

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**SIGNATURES**

The execution of this form and delivery thereof to the Plan Administrator revokes all prior designations of beneficiaries that I have made. The beneficiary designations made hereby shall become invalid if I am married at the time of my death unless my spouse has consented in writing to the designations made herein.

\_\_\_\_\_ Date \_\_\_\_\_ Participant's Signature

I, the undersigned, being the lawful spouse of the above named participant, do hereby consent to the beneficiaries designated by my spouse in this instrument. I understand that if this consent is in effect at the time of my spouse's death, I have waived any right I might then have to any benefit under the Plan payable due to the spouse's death, except to the extent that my spouse may name me specifically as a Beneficiary herein. This consent and waiver is my free and voluntary act. I understand that my consent is irrevocable unless my spouse revokes the above beneficiary designation.

\_\_\_\_\_ Date \_\_\_\_\_ Spouse's Signature

I, \_\_\_\_\_, a notary public for the County of \_\_\_\_\_ and the State of \_\_\_\_\_, do hereby certify that the above named participant's spouse appeared before me and acknowledged that he/she is the spouse of the participant, and that the above consent was signed by the participant's spouse.

Witness my hand and notary seal, this is the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_ Date \_\_\_\_\_ Plan Representative's or Notary Public's Signature

My Commission Expires: \_\_\_\_\_