



EQUITABLE

Equitable Retirement VisionSM

Beneficiary Designation
(Non-ERISA Plans)

Express Mail:
Equitable Retirement Plan Services
430 W 7th Street Suite 219886
Kansas City, MO 64105-1407
Regular Mail:
Equitable Retirement Plan Services
PO Box 219886
Kansas City, MO 64121-9886
Fax:
(833) 674-0745

For Assistance:
Customer Service Call (888) 234-5152

PLEASE PRINT

Use this form to designate your beneficiary for your retirement plan.

1. Employer Information

Name: _____ Unit Number: _____

2. Participant Information

Account #: _____

Name: First _____ MI _____ Last _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Date of Hire: _____ Date of Birth: _____ Gender: _____

Taxpayer Identification Number (Check One): ITIN or SSN _____

Email Address (required): _____

Mobile phone #: _____ Alternate phone #: _____

3. Beneficiary Designation

This designation will apply to all of your investments maintained in connection with Equitable Retirement VisionSM. If you do not designate a beneficiary or if no beneficiary survives you, your benefit will be paid in accordance with the terms of your Plan. If you designate a trust as a beneficiary, please include the name and TIN of the trust, the date the trust was created and the names of the trustees. If you need to name more beneficiaries than space allows, please attach a separate sheet with the same information. If you want to designate additional beneficiaries, please attach, sign and date a separate piece of paper with the same information as below.

(a) Primary Beneficiary(ies) (If more than one, indicate %)*:

Primary Beneficiary #1 Name: _____ %

Relationship to Participant: _____ SSN TIN/EIN _____ Date of Birth: _____

Address: _____ Phone Number: _____

Primary Beneficiary #2 Name: _____ %

Relationship to Participant: _____ SSN TIN/EIN _____ Date of Birth: _____

Address: _____ Phone Number: _____

Primary Beneficiary #3 Name: _____ %

Relationship to Participant: _____ SSN TIN/EIN _____ Date of Birth: _____

Address: _____ Phone Number: _____

3. Beneficiary Designation (Cont.)

(b) If all Primary Beneficiaries pre-decease me, I designate: (If more than one, indicate %)*

Contingent Beneficiary #1 Name: _____ %

Relationship to Participant: _____ SSN TIN/EIN _____ Date of Birth: _____

Address: _____ Phone Number: _____

Contingent Beneficiary #2 Name: _____ %

Relationship to Participant: _____ SSN TIN/EIN _____ Date of Birth: _____

Address: _____ Phone Number: _____

Contingent Beneficiary #3 Name: _____ %

Relationship to Participant: _____ SSN TIN/EIN _____ Date of Birth: _____

Address: _____ Phone Number: _____

*Please make sure that the percentages for each group of beneficiaries total 100%. If no percentage is indicated, benefits shall be divided equally among primary beneficiaries (or contingent beneficiaries).

4. Participant Signature and Acknowledgment

I hereby represent that all statements contained herein are full, complete, and true as written. I understand that the beneficiary information included in this form becomes effective when delivered to Equitable Retirement Plan Services in good order, and will remain in effect until I deliver another completed and signed form to Equitable Retirement Plan Services. By signing below, I request Equitable Retirement Plan Services to accept the beneficiary(ies) as specified on this form.

Participant Signature: _____ Date: _____