



# Lay Employees' Retirement Plan Beneficiary Designation Form for Plan Death Benefit

|  |  |     |                    |                                 |
|--|--|-----|--------------------|---------------------------------|
| <b>Participant Information</b>   |  |     |                    |                                 |
| Full name  | <i>Last, first, and middle</i>                             | SSN | <i>###-##-####</i> | Date of birth <i>MM/DD/YYYY</i> |
| Address  | <i>Street address or PO box, city, state, and zip code</i> |     | Phone              | <i>(###) ###-####</i>           |
| Status: <input type="checkbox"/> Active Participant (actively employed) <input type="checkbox"/> Terminated Vested Participant (former employee eligible for retirement) <input type="checkbox"/> Disability Retirant  |  |     |                    |                                 |
| <b>Beneficiary Designation</b> <i>Please refer to back page for additional information.</i>  |  |     |                    |                                 |
| <input type="checkbox"/> In furtherance of my participation in the Plan, I revoke all prior beneficiary designations, and I designate that any Death Benefit payable under the Plan at my death shall be paid to the following beneficiaries in the order specified below. |  |     |                    |                                 |
| <b>Primary Beneficiary or Beneficiaries</b> <i>'Percent' must total 100%. Please refer to back page for additional information.</i>  |  |     |                    |                                 |
| Full name  | <i>Last, first, and middle</i>                             | SSN | <i>###-##-####</i> | Date of birth <i>MM/DD/YYYY</i> |
| Address  | <i>Street address or PO box, city, state, and zip code</i> |     | Phone              | <i>(###) ###-####</i> Percent % |
| Full name  | <i>Last, first, and middle</i>                             | SSN | <i>###-##-####</i> | Date of birth <i>MM/DD/YYYY</i> |
| Address  | <i>Street address or PO box, city, state, and zip code</i> |     | Phone              | <i>(###) ###-####</i> Percent % |
| Full name  | <i>Last, first, and middle</i>                             | SSN | <i>###-##-####</i> | Date of birth <i>MM/DD/YYYY</i> |
| Address  | <i>Street address or PO box, city, state, and zip code</i> |     | Phone              | <i>(###) ###-####</i> Percent % |
| <b>Contingent Beneficiary or Beneficiaries</b> <i>'Percent' must total 100%. Please refer to back page for additional information.</i>   |  |     |                    |                                 |
| Full name  | <i>Last, first, and middle</i>                             | SSN | <i>###-##-####</i> | Date of birth <i>MM/DD/YYYY</i> |
| Address  | <i>Street address or PO box, city, state, and zip code</i> |     | Phone              | <i>(###) ###-####</i> Percent % |
| Full name  | <i>Last, first, and middle</i>                             | SSN | <i>###-##-####</i> | Date of birth <i>MM/DD/YYYY</i> |
| Address  | <i>Street address or PO box, city, state, and zip code</i> |     | Phone              | <i>(###) ###-####</i> Percent % |
| <input type="checkbox"/> <b>Please check here if you are attaching additional beneficiary information.</b> <i>Please indicate primary or contingent and include all above information.</i>   |  |     |                    |                                 |
| <b>Participant Signature</b> <i>You must sign and date this form for it to be valid</i>  |  |     |                    |                                 |
| Signature  |  |     |                    | Date <i>MM/DD/YYYY</i>          |

**Please return this completed form to:** Michigan Catholic Conference  
 Attention: Employee Benefits  
 510 South Capitol Avenue  
 Lansing, Michigan 48933



## Explanation of Death Benefit

The Amended and Restated Michigan Catholic Conference Lay Employees' Retirement Plan (the "Plan") provides that if you die after completing five or more years of credited service, but before you start to receive your Retirement Benefit, or if you die while receiving a Disability Retirement Benefit under the Plan, your beneficiary or beneficiaries are entitled to a Death Benefit. Your beneficiary will be the person or persons you designate on this Beneficiary Designation Form. If you fail to make a proper beneficiary designation on this form, or if none of your designated beneficiaries survive you, you will be deemed to have designated the following as your beneficiaries and contingent beneficiaries, in the following order of priority: (1) your descendants by right of representation, and (2) your estate.

The amount of your Death Benefit is equal to 80% of the actuarial equivalent of your Retirement Benefit, unless you die while receiving a Disability Retirement Benefit. In that event, the amount of your Death Benefit is equal to 80% of the actuarial equivalent of the anticipated remaining Disability Retirement Benefits owing to you immediately prior to your death. Your Death Benefit, if any, will be paid as a single sum within one year following your death. However, if (A) your beneficiary is one natural person, and (2) the value of your Death Benefit is at least \$50,000, your beneficiary may elect to receive the Death Benefit as a Straight Life Monthly Annuity.

## Beneficiary Designation

If you name a trust as your beneficiary of the Death Benefit payable under the Plan, the trustee of your trust will be required to provide the Michigan Catholic Conference with a certificate of trust meeting the requirements of MCL 700.7913 or a copy of the trust agreement before your Death Benefit can be paid to the trust.

## Right to Revoke Designation

You may revoke any designation made on this Form at any time by filing a new Beneficiary Designation Form with the Michigan Catholic Conference at the address shown below. No change in your beneficiary designation will be effective unless and until it is actually received by the Michigan Catholic Conference on this Form.