Form EMPLOYEES' RETIREMENT SYSTEM UNIFORMED RETIREMENT SYSTEM

This form is not for Police Officers

#A014_7-2-2023

Date Stamp Here

Retirement Date Stamp

Beneficiary Information Change Request

Last Name:	First Name:		Middle Initial:
Address:	City:	State:	Zip:
Social Security # *(last 4 digits)*:	Phone #:		

Beneficiary Designation - In the event of your death, having your beneficiary information on file with the Retirement Systems office will make handling your affairs easier for your survivors. Information can be changed at any time, but it must be changed by using this form. You may designate as many beneficiaries as you choose.

Employees who are VESTED, please note: In the event of your death prior to retirement, if you have a current spouse AND that spouse is listed as your **sole Primary Beneficiary**, that designated spouse will have the option of requesting a 50% survivor benefit payable to him/her for his/her lifetime, **OR** a refund of your contributions and interest. If you designate your spouse AND anyone else as your Primary Beneficiaries, the distribution of your account balance will be according to the percentages listed, and no spousal benefit will be applicable. Refunds are paid from the system within 60-90 days after receipt of a member's death certificate. For more information, please visit the Retirement Systems website.

Alternate Beneficiary is/are the payee(s) who will be paid if Primary Beneficiary is already deceased.

I have read and understand that **only my spouse** will have the option of requesting a 50% survivor benefit as long as he/she is my **sole primary beneficiary**.

A member may designate as many beneficiaries as he/she chooses. Make sure the information is clearly stated with regard to percentages for each beneficiary.

☐ *Check this box if you have provided any additional beneficiary names or information on another page.*

I am changing my Beneficiary Designation(s) to:

The total % of all Primary beneficiaries must equal 100%. The total % of all Alternate beneficiaries must equal 100%.			
PRIMARY	Name:		%
Relationship:	SSN *(last 4 digits)*:	DOB:	
Address if different from above:			
☐ Primary OR ☐ Alternate	Name:		%
Relationship:	SSN *(last 4 digits)*:	DOB:	
Address if different from above:			
☐ Primary OR ☐ Alternate	Name:		%
Relationship:	SSN *(last 4 digits)*:	DOB:	
Address if different from above:			
☐ Primary OR ☐ Alternate	Name:		%
Relationship:	SSN *(last 4 digits)*:	DOB:	
Address if different from above:			
☐ Primary OR ☐ Alternate	Name:		%
Relationship:	SSN *(last 4 digits)*:	DOB:	
Address if different from above:			

Member Signature: _____ ***Date:*** _____

Filing this form will replace prior filings. Please make a copy for your records.

Please return this original form to:

FAIRFAX COUNTY Retirement SYSTEMS
EMPLOYEES' POLICE Officers UNIFORMED

Fairfax County Retirement Systems
12015 Route 50 ∗ Suite 350 ∗ Fairfax, VA 22033
703-279-8200 ∗ TTY: 711 ∗ Fax: 703-653-9543
www.fairfaxcounty.gov/retirement/