

Date Stamp Here

# Beneficiary Change Request

Date Stamp Here

Last Name:		First Name:		Middle Initial:
Address:		City:	State:	Zip:
Social Security #:		Phone #:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: Month Day Year
<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	<input type="checkbox"/> New Hire	Start Date:	Department/ Agency:
<input type="checkbox"/> *Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Rehired**		

All new hires who participate in the Police Officers Retirement System (PORS), effective on or after July 1, 2019, will be members of **PORS Plan C**.

**In the event of your death**, having beneficiary information on file with the Retirement Systems will make handling your affairs easier for your survivors.

If you die, and you have a spouse and/or dependent children, they will receive the **automatic benefit** that is payable to surviving spouses and dependents of members of the Fairfax County Police Retirement System. **\*If you are married, only your spouse can be your primary beneficiary.** Please visit [www.fairfaxcounty.gov/retirement](http://www.fairfaxcounty.gov/retirement) for specific information on Police System death benefits.

If you do not have a spouse or dependent children at the time of your death, your beneficiary is entitled to a refund of all your contributions. Refunds are paid out of the system within 60-90 days after receipt of your death certificate.

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

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 a separate page.

<input type="checkbox"/> Primary OR <input type="checkbox"/> Alternate	Name:	%
Relationship:	SSN:	DOB:
Address if different from above:		
<input type="checkbox"/> Primary OR <input type="checkbox"/> Alternate	Name:	%
Relationship:	SSN:	DOB:
Address if different from above:		
<input type="checkbox"/> Primary OR <input type="checkbox"/> Alternate	Name:	%
Relationship:	SSN:	DOB:
Address if different from above:		
<input type="checkbox"/> Primary OR <input type="checkbox"/> Alternate	Name:	%
Relationship:	SSN:	DOB:
Address if different from above:		
*Comments (what was changed):		

Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please return this original form to: