



## DC PLAN RETIREE/SURVIVOR INFORMATION UPDATE

The purpose of this form is to facilitate the payment of appropriated benefits by Electronic Funds Transfer (EFT/Direct Deposit), to Defined Contribution (DC) Plan retirees and survivors. **DC Plan retirees and survivors, are required to annually complete and submit, a DC Plan Retiree/Survivor Information Update & Claim form.** The processing of future appropriated benefit payments may be withheld, until receipt of your updated form.

RETIREE/SURVIVOR'S NAME:	CHECK ONE <input type="checkbox"/> RETIREE <input type="checkbox"/> SURVIVOR	SOCIAL SECURITY NUMBER	DATE OF BIRTH
MAIDEN NAME, IF APPLICABLE	NAME OF RETIREE:		

MAILING ADDRESS	HOME PHONE NO.:	CELL PHONE NO.:	EMAIL ADDRESS:
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MARITAL STATUS <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> MARRIED <input type="checkbox"/> MARRIED, BUT SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	SPOUSE'S INFORMATION (AS APPLICABLE)		
	NAME:	MAIDEN NAME:	
	SSN:	DATE OF BIRTH:	DATE OF DEATH:

**Please provide certified copies of the applicable forms below.**

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| <input type="checkbox"/> CURRENT GOVERNMENT-ISSUED PHOTO I.D.<br><input type="checkbox"/> RETIREE/SURVIVOR'S BIRTH CERTIFICATE OR PASSPORT<br><input type="checkbox"/> SPOUSE'S BIRTH CERTIFICATE OR PASSPORT<br><input type="checkbox"/> MARRIAGE CERTIFICATE | <input type="checkbox"/> FINAL DECREE OF DIVORCE, including:<br><input type="checkbox"/> INTERLOCUTORY DECREE<br><input type="checkbox"/> MARITAL SETTLEMENT AGREEMENT<br><input type="checkbox"/> SPOUSE'S DEATH CERTIFICATE |
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### DESIGNATION OF BENEFICIARY

#### PRIMARY BENEFICIARY

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	RELATIONSHIP	%
ADDRESS				
NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	RELATIONSHIP	%
ADDRESS				

**If you are designating more than two (2) beneficiaries, please complete additional Designation of Beneficiary Forms, as necessary. Number each page and indicate the total number of pages, accordingly. For Example: Page 1 of 2, Page 2 of 2, etc.**

#### CONTINGENT BENEFICIARY

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	RELATIONSHIP	%
ADDRESS				
NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	RELATIONSHIP	%
ADDRESS				

The foregoing is made with my understanding and in accordance with the following conditions:

- 1) Should a beneficiary or beneficiaries survive in the event of my death, but all die before the benefits due or to become due have been paid, such unpaid benefits shall be paid to the estate of the last surviving beneficiary.
- 2) Should no beneficiary or beneficiaries herein designated survive the event of my death, any benefits due or to become due shall be payable to my estate, or to such other beneficiary or beneficiaries as I shall hereinafter nominate by written designation and file with the Board of Trustees.
- 3) This instrument shall become effective without further notice upon receipt by the Board of Trustees, and is made subject to all the provisions of the Retirement Law.

**§8169. Penalties. Any person who knowingly makes any false statement or falsifies or permits to be falsified, any record or records of this system, in any attempt to defraud the system, is guilty of a misdemeanor and shall be punishable therefore under the laws of the Government of Guam, and the system shall have the right to recover any payments made under false representations.**

**Under the laws of perjury, I hereby certify that the information I have provided is true and correct.**

**Unless the DC Plan Retiree/Survivor Information Update & Claim Form is signed by the retiree/survivor in the presence of a Retirement Fund representative, notarization is required.**

Retiree / Survivor's Signature & Date

Print Name / Signature & Date