PATHFINDER OKLAHOMA

Beneficiary Designation Governmental 457(b) Plan

Oklahoma Pathfinder 457 Plan **98788-02**

For My Information

- *For questions regarding this form, visit the website at www.okpathfinder.com or contact Service Provider at 1-844-465-7284.*
- *Use black or blue ink when completing this form.*

A Participant Information

Account extension, if applicable, identifies funds transferred to a beneficiary due to participant's death, alternate payee due to divorce or a participant with multiple accounts.

Account Extension

Social Security Number *(Must provide all 9 digits)* ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Last Name First Name M.I.
(The name provided MUST match the name on file with Service Provider.)

Date of Birth / /

Daytime Phone Number ( )

Email Address

Alternate Phone Number ( )

❑ Married ❑ Unmarried

B Beneficiary Designation *(Attach an additional sheet to name additional beneficiaries.)*

Primary Beneficiary Designation *(Primary beneficiary designations must total 100% - percentage can be made out to two decimal places.)*

- See the attached examples on how to complete the below beneficiary designations if the beneficiary is a non-individual, such as a trust, charity or estate.

% of Account Balance % | Primary Beneficiary Name *(Name of Individual, Trust, Charity, etc.)* | Social Security or Taxpayer Identification Number | Date of Birth or Trust Date / /

Street Address | City | State | Zip Code

Phone Number *(Optional)* ( )

Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*
❑ Spouse ❑ Child ❑ Parent ❑ Grandchild ❑ Sibling ❑ My Estate ❑ A Trust ❑ Other ❑ Domestic Partner

% of Account Balance % | Primary Beneficiary Name *(Name of Individual, Trust, Charity, etc.)* | Social Security or Taxpayer Identification Number | Date of Birth or Trust Date / /

Street Address | City | State | Zip Code

Phone Number *(Optional)* ( )

Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*
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% of Account Balance % | Primary Beneficiary Name *(Name of Individual, Trust, Charity, etc.)* | Social Security or Taxpayer Identification Number | Date of Birth or Trust Date / /

Street Address | City | State | Zip Code

Phone Number *(Optional)* ( )

Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*
❑ Spouse ❑ Child ❑ Parent ❑ Grandchild ❑ Sibling ❑ My Estate ❑ A Trust ❑ Other ❑ Domestic Partner

Contingent Beneficiary Designation *(Contingent beneficiary designations must total 100% - percentage can be made out to two decimal places.)*

% of Account Balance % | Contingent Beneficiary Name *(Name of Individual, Trust, Charity, etc.)* | Social Security or Taxpayer Identification Number | Date of Birth or Trust Date / /

Street Address | City | State | Zip Code

Phone Number *(Optional)* ( )

Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*
❑ Spouse ❑ Child ❑ Parent ❑ Grandchild ❑ Sibling ❑ My Estate ❑ A Trust ❑ Other ❑ Domestic Partner

Last Name	First Name	M.I.	Social Security Number	98788-02 Number

B Beneficiary Designation *(Attach an additional sheet to name additional beneficiaries.)*

Contingent Beneficiary Designation *(Contingent beneficiary designations must total 100% - percentage can be made out to two decimal places.)*

% of Account Balance	Contingent Beneficiary Name *(Name of Individual, Trust, Charity, etc.)*	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date
%			/ /

Street Address | City | State | Zip Code

( ) Phone Number *(Optional)*

Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*

❑ Spouse ❑ Child ❑ Parent ❑ Grandchild ❑ Sibling ❑ My Estate ❑ A Trust ❑ Other ❑ Domestic Partner

% of Account Balance	Contingent Beneficiary Name *(Name of Individual, Trust, Charity, etc.)*	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date
%			/ /

Street Address | City | State | Zip Code

( ) Phone Number *(Optional)*

Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*

❑ Spouse ❑ Child ❑ Parent ❑ Grandchild ❑ Sibling ❑ My Estate ❑ A Trust ❑ Other ❑ Domestic Partner

C Participant Consent for Beneficiary Designation *(Please sign on the 'Participant Signature' line below.)*

I have completed, understand and agree to all pages of this Beneficiary Designation form. Subject to and in accordance with the terms of the Plan, I am making the above beneficiary designations for my vested account in the event of my death. If I have more than one primary beneficiary, the account will be divided as specified. If a primary beneficiary predeceases me, his or her benefit will be allocated to the surviving primary beneficiaries. Contingent beneficiaries will receive a benefit only if there is no surviving primary beneficiary, as specified. If a contingent beneficiary predeceases me, his or her benefit will be allocated to the surviving contingent beneficiaries. If I fail to designate beneficiaries, amounts will be paid pursuant to the terms of the Plan or applicable law. This designation is effective upon execution and delivery to Service Provider. If any information is missing, additional information may be required prior to recording my designation.

This designation supersedes all prior designations. Beneficiaries will share equally if percentages are not provided and any amounts unpaid upon death will be divided equally. **Primary and contingent beneficiaries must separately total 100%. The percentages can be divided up to two decimal points (Example: 33.33%).**

I understand that Service Provider is required to comply with the regulations and requirements of the Office of Foreign Assets Control, Department of the Treasury ("OFAC"). As a result, Service Provider cannot conduct business with persons in a blocked country or any person designated by OFAC as a specially designated national or blocked person. For more information, please access the OFAC website at: http://www.treasury.gov/about/organizational-structure/offices/Pages/Office-of-Foreign-Assets-Control.aspx.

Any person who presents a false or fraudulent claim is subject to criminal and civil penalties.

Participant Signature _____ **Date *(Required)*** _____

***A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay*.**

D Delivery Instructions

Participant forward this form to:

Oklahoma Pathfinder Plans
PO Box 53007
Oklahoma City, OK 73152
Fax: 1-405-848-5946

After all signatures have been obtained, this form can be

Sent Regular Mail to:
Empower Retirement
PO Box 173764
Denver, CO 80217-3764

OR

Sent Express Mail to:
Empower Retirement
8515 E. Orchard Road
Greenwood Village, CO 80111

We will not accept hand delivered forms at Express Mail addresses.