Beneficiary Designation/ Name & Address Change - 457(b) and 401(a)

Mail Address:
MassMutual Retirement Services
PO Box 1583
Hartford, CT 06144-1583

Overnight Mail Address
MassMutual Retirement Services
1 Griffin Road North
Windsor, CT 06095-1512

Group Number:	Social Security Number:	Employer:
110147		City of Stamford

Employee Name: *Last, First,M.I.*
☐ Name Change? Please provide documentation

Mailing Address:
☐ New?

City:	State:	Zip:

Home Phone:	Work Phone:	Ext:

BENEFICIARY INFORMATION

Please complete the Beneficiary Designation including name, address, phone number, Social Security Number, date of birth, relationship and percentage of death benefit. The percent of benefit must total 100% for all primary beneficiaries named. If naming contingent beneficiary(ies) the total percentage for this designation must equal 100%. Married residents of community property states may want to seek legal advice if naming a non-spouse Primary Beneficiary.

Type of Beneficiary:		**Examples of Designations:**
One Beneficiary		Jane Doe, wife, 100%
Two or more Primary Beneficiaries, ***equally among the survivors***		John Doe, son, 33% Carol Smith, daughter, 33% Mark Doe, son 34% or equally among the survivors
Two or more Primary Beneficiaries, ***with their share to their children***		John Doe, son, 33% Carol Smith, daughter, 33% Mark Doe, son 34% per stirpes
Primary and Contingent Beneficiaries		Primary: Jane Doe, wife, 100% if living; Contingent: John Doe, son, 33% Carol Smith, daughter, 33% Mark Doe, son 34%
	either	equally among the survivors
	or	per stirpes
Participant's Estate		Participant's Estate
Trustee		Jane Doe, trustee under trust agreement* dated...

** Date of the execution of the trust agreement or a copy of the trust agreement **must** be provided.*

Primary Beneficiary(ies) name, address and phone no.	Social Security No.	Date of Birth	Relationship	%
			PRIMARY TOTAL:	**100%**

Contingent Beneficiary(ies) name, address and phone no.	Social Security No.	Date of Birth	Relationship	%
			CONTINGENT TOTAL:	**100%**

The execution and the delivery of this form to the offices of MassMutual revokes all prior beneficiary designations that I have made. I understand that this beneficiary designation will not take effect until it has been received in good order by MassMutual.

Employee Signature _____ Date _____

Mail this Beneficiary Designation to MassMutual at the address above. Keep a copy for your records.

HVL-464-3 Rev. 4.13 ***Please provide a copy of this Beneficiary Designation to your Employer.*** benedcp.pdf

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