BENEFICIARY DESIGNATION FORM

SouthCoast Medical Group, LLC

Plan Number: 878758

Request Type ☐ **Initial Designation** ☐ **Change to Designation**

Participant Information

Name (first, middle initial, last)	Social Security Number - -	☐ Married ☐ Single

Beneficiary Information

Subject to the terms of my Employer's Plan, I request that any sum becoming due upon my death be payable to the beneficiary(ies) designated below. I understand this designation shall revoke all prior beneficiary designations made by me under my Employer's Plan. *(All designations must be in whole percentages. Total percentage must equal 100% for Primary Beneficiary and 100% for Contingent Beneficiary, if designated.)*

1. Beneficiary Name (complete legal name required)	Relationship	☒ Primary Beneficiary	Percentage
Address and Phone #	Social Security Number		Date of Birth (mm/dd/yyyy)
2. Beneficiary Name (complete legal name required)	Relationship	☐ Primary Beneficiary ☐ Contingent Beneficiary	Percentage
Address and Phone #	Social Security Number		Date of Birth (mm/dd/yyyy)
3. Beneficiary Name (complete legal name required)	Relationship	☐ Primary Beneficiary ☐ Contingent Beneficiary	Percentage
Address and Phone #	Social Security Number		Date of Birth (mm/dd/yyyy)
4. Beneficiary Name (complete legal name required)	Relationship	☐ Primary Beneficiary ☐ Contingent Beneficiary	Percentage
Address and Phone #	Social Security Number		Date of Birth (mm/dd/yyyy)
5. Beneficiary Name (complete legal name required)	Relationship	☐ Primary Beneficiary ☐ Contingent Beneficiary	Percentage
Address and Phone #	Social Security Number		Date of Birth (mm/dd/yyyy)
6. Beneficiary Name (complete legal name required)	Relationship	☐ Primary Beneficiary ☐ Contingent Beneficiary	Percentage
Address and Phone #	Social Security Number		Date of Birth (mm/dd/yyyy)

Unless otherwise requested:

1. If more than one beneficiary is designated, payment will be made in equal shares to the primary beneficiaries who survive the participant or annuitant or, if none survives the participant or annuitant, in equal shares to the contingent beneficiaries who survive the participant or annuitant.
2. If no beneficiary survives the participant or annuitant, payment will be made to the executors or administrators of the estate of the participant or annuitant.
3. If a class of beneficiaries is designated (such as, *"the children of the participant or annuitant"*), then payment will be made in equal shares to each person who is a member of the class and living at the death of the participant or annuitant whether or not he/she has been specifically named in the beneficiary designation.
4. If you name an Estate or Trust as beneficiary, contact your Plan Administrator for more information.

Beneficiary Designation Form (continued)

SouthCoast Medical Group, LLC

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Name (first, middle initial, last)	Social Security Number - -

Certification

- ☐ I am not married at the time I am making this beneficiary designation. I understand that if I later marry, I must submit a new designation naming my spouse as beneficiary, unless he or she agrees in writing to a different beneficiary.
- ☐ I am married and have named my spouse as sole/primary beneficiary.
- ☐ I am married and have named someone other than my spouse as sole/primary beneficiary and my spouse agrees to such designation (spouse must also sign below in the presence of a Notary Public or Plan Representative).

Participant's Signature	Signed in City/Town and State	Date (mm/dd/yyyy)

Witness' Name	Witness' Signature

Spousal Consent

This is to certify that I am the spouse of the above named participant and agree with the beneficiary designation. I understand that the above designation specifies the only person(s) who will receive any death benefits payable in the event of death of the participant.

Spouse's Name	Social Security Number

Spouse's Signature	Date (mm/dd/yyyy)

State of _____, County of _____
On this _____ day of _____, in the year of _____, before me, _____ the undersigned officer, personally appeared _____ known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument and acknowledged that he/she executed for the same purpose therein contained.
In Witness Whereof, I hereunto set my hand

_____ or _____
Notary Public Plan Representative

Please complete this form and return it to your Plan Administrator.