

UNIVERSITY OF MISSOURI RETIREMENT, DISABILITY AND DEATH BENEFIT PLAN

DESIGNATION OF BENEFICIARY FOR GUARANTEED PERIOD

Complete this form only if you have elected a guaranteed period. This form is not valid until received by Retirement Benefits Office.

I hereby designate the beneficiary(ies) listed below to receive applicable benefits under the provisions of the University of Missouri Retirement, Disability and Death Benefit Plan Guaranteed Period Option, and I hereby revoke any and all previous beneficiary designations.

Retiree Signature: _____ Date: _____

Retiree Name: _____
Last First Middle

S.S.N. _____ Employee ID # _____

I hereby designate the following beneficiary(ies) for the payment of the Guaranteed Period.

Name:	SSN:
Address:	Date of Birth:
City, State, Zip:	Percent:

Name:	SSN:
Address:	Date of Birth:
City, State, Zip:	Percent:

Name:	SSN:
Address:	Date of Birth:
City, State, Zip:	Percent:

Name:	SSN:
Address:	Date of Birth:
City, State, Zip:	Percent:

Note: Percentage allocation must equal 100%.

Return completed form to:
UM System Office of Human Resources
1105 Carrie Francke Dr., Suite 108
Columbia, MO 65211-8220