SCMEBF Designation of Beneficiary Form

Bereavement (Active $25k*)

If you would like separate forms for each benefit, please visit scmebf.org/forms or call the Benefit Fund at 631-319-4099

Please PRINT clearly:

NAME: _____ SSN: _____

HOME ADDRESS: _____ FORMER NAME: _____

CITY, STATE: _____ DATE OF BIRTH: _____

_____ _____

MEMBER'S SIGNATURE DATE

I hereby name the following BENEFICIARY(S) to receive the Bereavement & Survivors Benefit, payable on my behalf. I reserve the right to change the designation at any time. If the named beneficiary predeceases me, this benefit payable on my behalf shall be paid to the CONTINGENT beneficiary listed below. I reserve the right to change my designation at any time. Social security numbers of any listed beneficiary must be provided.

1. NAME: _____ SSN: _____

HOME ADDRESS: _____ RELATIONSHIP: _____ BENEFICIARY ☐ CONTINGENT ☐ *(Check Only One)*

CITY, STATE: _____ DATE OF BIRTH: _____ _____ **%**

2. NAME: _____ SSN: _____

HOME ADDRESS: _____ RELATIONSHIP: _____ BENEFICIARY ☐ CONTINGENT ☐ *(Check Only One)*

CITY, STATE: _____ DATE OF BIRTH: _____ _____ **%**

3. NAME: _____ SSN: _____

HOME ADDRESS: _____ RELATIONSHIP: _____ BENEFICIARY ☐ CONTINGENT ☐ *(Check Only One)*

CITY, STATE: _____ DATE OF BIRTH: _____ _____ **%**

4. NAME: _____ SSN: _____

HOME ADDRESS: _____ RELATIONSHIP: _____ BENEFICIARY ☐ CONTINGENT ☐ *(Check Only One)*

CITY, STATE: _____ DATE OF BIRTH: _____ _____ **%**

*If the active employee is over 70 years of age at time of death, the Bereavement benefit is reduced by 50%.

Sworn to before me this _____

day of _____, 20____

_____

NOTARY PUBLIC

Please mail the completed form to:

Suffolk County Municipal Employees Benefit Fund
30 Orville Drive, Ste D
Bohemia, NY 11716-2513