BENEFICIARY DESIGNATION
RSA-1 & PEIRAF

Type of Account:
☐ PEIRAF
☐ RSA-1

Retirement Systems of Alabama
P. O. Box 302150 ♦ Montgomery, AL 36130-2150
334-517-7000 or 877-517-0020
www.rsa-al.gov

Name _____
First   Middle/Maiden   Last

Address _____
Street or P. O. Box

_____
City   State   Zip Code

Social Security Number _____   **Phone Number** _____

(   ) Check if Beneficiary information is continued on the back of this form.

DESIGNATION OF PRIMARY BENEFICIARY(IES)

I hereby designate the following person(s) as my primary beneficiary(ies) to receive any benefit that may become due at or after my death according to the terms of the Plan.

Name:_____   Relationship: _____   Date of Birth: _____
                                                                                                        mm/dd/yyyy
_____   Address: _____
Social Security Number   Street or P. O. Box   City   State   Zip Code

Name:_____   Relationship: _____   Date of Birth: _____
                                                                                                        mm/dd/yyyy
_____   Address: _____
Social Security Number   Street or P. O. Box   City   State   Zip Code

Name:_____   Relationship: _____   Date of Birth: _____
                                                                                                        mm/dd/yyyy
_____   Address: _____
Social Security Number   Street or P. O. Box   City   State   Zip Code

DESIGNATION OF CONTINGENT BENEFICIARY(IES)

In the event the primary beneficiary(ies) does **not** survive me, I hereby designate the following person(s) as my contingent beneficiary(ies) to receive any benefit that may become due at or after my death according to the terms of the Plan.

Name:_____   Relationship: _____   Date of Birth: _____
                                                                                                        mm/dd/yyyy
_____   Address: _____
Social Security Number   Street or P. O. Box   City   State   Zip Code

Name:_____   Relationship: _____   Date of Birth: _____
                                                                                                        mm/dd/yyyy
_____   Address: _____
Social Security Number   Street or P. O. Box   City   State   Zip Code

Name:_____   Relationship: _____   Date of Birth: _____
                                                                                                        mm/dd/yyyy
_____   Address: _____
Social Security Number   Street or P. O. Box   City   State   Zip Code

Signature _____   **Date** _____

STATE OF_____, COUNTY OF _____

Before me appeared _____, known to me to be the person who subscribed to the foregoing instrument on this _____ day of _____, 20_____.

Signature of Notary Public _____

Seal

My Commission Expires _____

If completing this side of the form, do not forget to sign at the bottom.

Name _____   **Social Security Number** _____

MULTIPLE BENEFICIARIES DESIGNATION (Continued)

DESIGNATION OF PRIMARY BENEFICIARIES (Continued)

Name:_____   Relationship: _____   Date of Birth: _____
                                                                                             mm/dd/yyyy
_____   Address: _____
Social Security Number   Street or P. O. Box   City   State   Zip Code

Name:_____   Relationship: _____   Date of Birth: _____
                                                                                             mm/dd/yyyy
_____   Address: _____
Social Security Number   Street or P. O. Box   City   State   Zip Code

Name:_____   Relationship: _____   Date of Birth: _____
                                                                                             mm/dd/yyyy
_____   Address: _____
Social Security Number   Street or P. O. Box   City   State   Zip Code

Name:_____   Relationship: _____   Date of Birth: _____
                                                                                             mm/dd/yyyy
_____   Address: _____
Social Security Number   Street or P. O. Box   City   State   Zip Code

Name:_____   Relationship: _____   Date of Birth: _____
                                                                                             mm/dd/yyyy
_____   Address: _____
Social Security Number   Street or P. O. Box   City   State   Zip Code

DESIGNATION OF CONTINGENT BENEFICIARIES (Continued)

Contingent Beneficiaries will receive benefits only if all Primary Beneficiaries are deceased.

Name:_____   Relationship: _____   Date of Birth: _____
                                                                                             mm/dd/yyyy
_____   Address: _____
Social Security Number   Street or P. O. Box   City   State   Zip Code

Name:_____   Relationship: _____   Date of Birth: _____
                                                                                             mm/dd/yyyy
_____   Address: _____
Social Security Number   Street or P. O. Box   City   State   Zip Code

Name:_____   Relationship: _____   Date of Birth: _____
                                                                                             mm/dd/yyyy
_____   Address: _____
Social Security Number   Street or P. O. Box   City   State   Zip Code

Name:_____   Relationship: _____   Date of Birth: _____
                                                                                             mm/dd/yyyy
_____   Address: _____
Social Security Number   Street or P. O. Box   City   State   Zip Code

Signature*_____   **Date** _____

*Page two must be signed if any beneficiary information is submitted on this side of the form.