This beneficiary designation supercedes any prior designation.

HRSA-ILA Annuity & Savings Plan Beneficiary Designation/Change

Account Number **SF 51506 - 1 - 1**

PARTICIPANT INFORMATION (IF THE FORM IS NOT TOTALLY COMPLETED IT WILL BE RETURNED TO YOU FOR COMPLETION.)

Name ______________________ ______________________ ______________________
first middle last

Social Security No. ______________________ ☐ Single ☐ Married ☐ Separated/Divorced

BENEFICIARY DESIGNATION/CHANGE THIS DESIGNATION SUPERSEDES ANY PRIOR DESIGNATION

Primary Beneficiary: (Check either box 1 or 2)

1. ☐ **Spouse Primary Beneficiary:** I would like my spouse to receive my entire account balance at my death.

   Spouse's name: ____

   Note: In the event of divorce, your designation of your former spouse as beneficiary shall automatically be terminated, unless you re-designate that person as your Beneficiary.

2. ☐ **Non-Spouse Primary Beneficiary:** I would like the following person(s) to receive my account balance upon my death: (If division is other than equal shares, write in percentages.) If multiple beneficiaries are named and one or more predeceases you, the benefit will be distributed pro rata to the remaining designated beneficiaries. Only upon death of all named primary beneficiaries will the secondary beneficiary receive a distribution.

Name	Social Security #	Relationship	Percent
Name	Social Security #	Relationship	Percent
Name	Social Security #	Relationship	Percent

If you are married and you have not elected your spouse as primary beneficiary, your spouse must provide consent below.

SPOUSAL CONSENT. I understand that I have a legal right to a death benefit equal to the participant's entire account balance. I consent to waive that legal right in accordance with the beneficiary designation set forth above. I further understand and acknowledge that if I sign this form, no death benefit will be payable to me except as provided above.

____ ________/________/________
Spouse's Signature Date

____ ________/________/________
Notary Public Signature Date Date Commission Expires

(THE SPOUSAL CONSENT SECTION MUST BE COMPLETED)

Secondary Beneficiary (optional): If no Primary Beneficiary listed above is alive at my death, the following person(s) should receive my account balance at my death: (If division is other than equal shares, write in percentages.)

Name	Social Security #	Relationship	Percent
Name	Social Security #	Relationship	Percent

SIGNATURES

______________________________ ________/________/________
Participant Date

____
Witness (The witness must be someone other than the beneficiary):

______________________________________ __________/________/________
Plan Administrator Date

Form A&S-3