THE UNIVERSITY OF
SCRANTON
A JESUIT UNIVERSITY

Office of Human Resources

Change in Marital Status
Add or Remove a Spouse/Dependent Packet

Benefit forms need to be completed when a benefit eligible staff or faculty member changes address, marital status, and/or benefit plan enrollment. These forms need to be completed and returned to the Human Resources office within 30 days of the qualifying event and/or status change.

- ✓ Qualifying Events: A change in your situation — like getting married, having a baby or losing health coverage — that can allow benefit plan changes outside the yearly Open Enrollment Period.
- ✓ Verifying dependents: [illegible] University Benefits documentation [illegible] required

You only need to complete the forms that pertain to you.

Forms to be returned for a marital status change, including adding or removing a spouse or dependent:

- Office of Human Resources Data Change Form
- W-4 (only if you wish to change your federal withholding)
- Residency Certification
- Highmark Enrollment
  - Only complete section 1, *Employee Information*; complete section 2 *Dependent Information to* add/remove a spouse or dependent
- United Concordia Dental Enrollment
  - [illegible] remove a spouse or dependent
- Retirement Vendor Information Change Form
  - Only complete the form for the vendor you have an account with
- Medical/Dental Enrollment Option Form
- TIAA or Transamerica Beneficiary Designation Form
  - Only complete the form for the vendor you have an account with and only if you are choosing to update the beneficiary
- Cigna Life Insurance Beneficiary Designation Form *(not in the packet, must be opened separately)*
  - Only complete the form for the vendor you have an account with and only if you are choosing to update the beneficiary

All forms are available in the Office of Human Resources, St Thomas Hall room 100

Office of Human Resources

Data Change Form

Please print all information in ink.

Name: _____ R# _____

Effective Date of Change: _____

Check the appropriate box(es) to indicate a change to my personal information as indicated below:

☐ Name: _____ *Please provide supporting documentation*

☐ Physical Address: _____ ☐ If different, provide Mailing:

_____ _____

_____ _____

_____ _____

☐ Telephone Number: _____ ☐ Home ☐ Cell

☐ Marital Status: *Please provide supporting documentation (marriage certificate or divorce decree)*

☐ Single ☐ Married ☐ Widowed ☐ Divorced

☐ Add ☐ Remove the following spouse/dependent(s):

Name	Relationship	Gender	Date of Birth	Social Security #
	☐ Dependent	☐ Female		
	☐ Dependent	☐ Female		
	☐ Dependent	☐ Female		

Change emergency contact person: (if applicable)

_____ *(Name)*

_____ *(Address)*

_____ *(City, State, Zip)*

_____ *(Phone Number)*

_____ *(Signature)*

_____ *(Date)*

Highmark _____

Received in HR

CLGS-32-6 (5-13)

RESIDENCY CERTIFICATION FORM
Local Earned Income Tax Withholding

TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers and/or taxpayers to report essential information for the collection and distribution of Local Earned Income Taxes to the local EIT collector. This form must be completed by employers ... Use the Address Search Application at www.newPA.com/Act32 to determine PSD codes, EIT rates and ...

EMPLOYEE INFORMATION – RESIDENCE LOCATION

STREET ADDRESS (No PO Box, RD or RR)

ADDRESS LINE 2

CITY | STATE | ZIP CODE | DAYTIME PHONE NUMBER

MUNICIPALITY (City, Borough or Township)

COUNTY | RESIDENT PSD CODE | TOTAL RESIDENT EIT RATE

EMPLOYER INFORMATION – EMPLOYMENT LOCATION

EMPLOYER BUSINESS NAME (Use Federal ID Name): University of Scranton | 2 4 0 7 9 5 4 9 5

STREET ADDRESS WHERE ABOVE EMPLOYEE REPORTS TO WORK (No PO Box, RD or RR): 800 Linden St.

ADDRESS LINE 2

CITY: Scranton | STATE: PA | ZIP CODE: 18510 | PHONE NUMBER

MUNICIPALITY (City, Borough or Township): Scranton

COUNTY: Lackawanna | WORK LOCATION PSD CODE | WORK LOCATION NON-RESIDENT EIT RATE

CERTIFICATION

... schedules and statements and to the best of my (our) belief, they are true, correct and complete.

SIGNATURE OF EMPLOYEE | DATE (MM/DD/YYYY)

PHONE NUMBER | EMAIL ADDRESS

For information on obtaining the appropriate MUNICIPALITY (City, Borough, Township), PSD CODES and EIT (Earned Income Tax) RATES, please refer to the Pennsylvania Department of Community & Economic Development website:

www.newPA.com/Act32

Form **W-4** | Employee's Withholding Certificate | OMB No. 1545-0074

Department of the Treasury
Internal Revenue Service

▶ Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
▶ Give Form W-4 to your employer.

2022

Step 1: Personal Information

(a) First name and middle initial | Last name | (b) Social security number

Address

City or town, state, and ZIP code

card? If not, to ensure you get www.ssa.gov.

(c) ☐ Single or Married filing separately
☐ Married filing jointly or Qualifying widow(er)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, and privacy.

Step 2: Multiple Jobs or Spouse Works

Do only one of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); or

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; or

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate

☐ TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only this job. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

Multiply the number of qualifying children under age 17 by $2,000 ▶ $

Multiply the number of other dependents by $500 ▶ $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income | 4(a) |

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here | 4(b) $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) ▶ | Date ▶

Employer Use Only

Employer's name and address | Employer identification number (EIN) | First date of employment

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to www.irs.gov/FormW4.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you

when changes to your personal or financial situation would

withholding and when you must furnish

see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2022 if you meet both of the following conditions: you had no federal income tax liability in 2021 and you expect to have no federal income tax liability in 2022. You had no federal income tax liability in 2021 if (1)

is zero (or less than the sum of lines 27a, 28, 29, and 30), or (2) you were not required to file a return because your

status. If you claim exemption, you will have no income tax

Steps 2 through 4, use the online estimator, which will also

with Step 2(c), you may choose Step 2(b); if you have

you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box

significantly reduce your paycheck (often by thousands of dollars over the year).

2. Have dividend or capital gain income, or are subject to additional taxes, such as Additional Medicare Tax;

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

you need to have withheld, while option (b) does so with a little less accuracy.

If you (and your spouse) have a total of only two jobs, you may instead check the box in option (c). The box must also

checked, the standard deduction and tax brackets will be

two jobs.

Multiple jobs. Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your

be under age 17 as of December 31, must be your

credits. To do so, add an estimate of the amount for the year

and reduce the amount of any refund you may receive when

Step 4 (optional).

income from any jobs or self-employment. If you complete

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5. If you expect to claim

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on only ONE Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

1 Two jobs. If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . 2a $

Three jobs. If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . 2a $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . 2b $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . 2c $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. 3

4 Divide the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount you want withheld) . . . . . 4 $

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2022 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses (only those exceeding 7.5% of your income) . . . . . 1 $

2 Enter: { • $25,900 if you're married filing jointly or qualifying widow(er) / • $19,400 if you're head of household / • $12,950 if you're single or married filing separately } . . . . . 2 $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . 3 $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . . 4 $

Privacy Act and Paperwork Reduction Act Notice. We ask for the information . . . You are not required to provide the information requested on a form that is

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable	Lower Paying Job Annual Taxable Wage & Salary											
	$0	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000	$110,000
$20,000 - 29,999	850	1,860	2,860	3,000	3,160	3,160	3,160	3,160	3,910	4,910	5,910	6,010
$30,000 - 39,999	1,020	2,220	3,160	3,960	4,270	6,270	6,270	7,970	8,970	8,970	10,970	10,970
$260,000 - 279,999	2,040	4,440	6,680	7,980	9,340	10,540	11,740	12,940	14,140	16,100	18,100	19,190
$280,000 and over	2,140	4,540	6,780	8,080	9,440	10,640	11,840	13,040	14,240	16,200	18,200	19,290

Single or Married Filing Separately

Higher Paying Job Annual Taxable	Lower Paying Job Annual Taxable Wage & Salary											
	$0	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000	$110,000
$30,000 - 39,999	1,020	1,890	2,990	3,990	4,990	5,610	5,710	5,910	6,110	6,310	6,380	6,380
$200,000 - 249,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$450,000 and over	3,140	6,290	8,980	11,380	13,880	16,010	17,510	19,010	20,510	22,010	23,380	24,680

Head of Household

Higher Paying Job Annual Taxable	Lower Paying Job Annual Taxable Wage & Salary											
Wage & Salary	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$760	$1,010	$1,020	$1,020	$1,020	$1,190	$1,870	$1,870	$1,870	$2,040	$2,040
$10,000 - 19,999	760	1,820	2,110	2,220	2,220	2,390	3,390	4,070	4,070	4,240	4,440	4,440

HIGHMARK

ENROLLMENT/WAIVER FORM

COMPLETE THIS APPLICATION IN ITS ENTIRETY

IN BLUE OR BLACK INK.

☐ ENROLLING
(Complete sections I, II, IV, and V)

(Complete sections I and III)

Effective Date | Employer Group Name

First Name

Address

City | State | Zip | County | Home/Cell Phone

☐ Single/Widowed ☐ Married ☐ Active Employee ☐ COBRA ☐ HIPAA Life Event

☐ Divorced

Full-Time Hire (or rehire) Date (Month/Day/Year) | Hours Worked Per Week

Gender | Date of Birth (Month/Day/Year)

☐ Male ☐ Female / /

Full Name of Physician of Record (POR)/Group Practice | POR Number from Provider Directory | Are you an Established Patient?

☐ Yes ☐ No

First Name | MI | Last Name | Relationship to Your

☐ Spouse ☐ Domestic Partner†

Social Security Number (For Use by Athletes) | ☐ Male ☐ Female | / /

Product Selection(s):

☐ Medical ☐ Vision ☐ Dental

POR Number from Provider Directory | Is Spouse/DP an Established Patient?

☐ Yes ☐ No

☐ Male ☐ Female / /

Product Selection(s):

☐ Medical ☐ Vision ☐ Dental

Full Name of Physician of Record (POR)/Group Practice | POR Number from Provider Directory | Is Spouse/DP an Established Patient?

☐ Yes ☐ No

of Medical papers to support dependent

☐ Male ☐ Female

☐ Medical ☐ Vision ☐ Dental

☐ Yes ☐ No

MI | Last Name | Relationship to You? ☐ Child

☐ Yes ☐ No

eligibility.

*If your employer offers Act 4 adult dependent coverage, complete and attach an Act 4 Dependent Verification Form.

MEDICAL

REASON FOR DECLINING MEDICAL COVERAGE:

☐ For myself
☐ For family members ONLY:
☐ For myself and ALL family members
☐ For the following family members:

☐ Insured under spouse. Please provide spouse's employer and insurance carrier names:

☐ Other:

VISION

I HEREBY DECLINE VISION COVERAGE:

☐ For family members ONLY
☐ For the following family members:

DENTAL

I HEREBY DECLINE DENTAL COVERAGE:

☐ For myself
☐ For family members ONLY
☐ For myself and ALL family members
☐ For the following family members:

Name of Insurance Carrier	Group Number	Effective Date / /	Name of Policyholder
Policyholder Date of Birth / /			Policyholder Employment Status ☐ Active ☐ Retired Date of Retirement: / /

Medicare Coverage (Please list any family member that is eligible for Medicare Benefits)

Name of Subscriber or Dependent	Health Insurance Claim Number	Effective Dates			Check (✓) the box for Medicare Coverage			Medicare Supplement	
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End Stage Renal Disease		
									☐ Yes ☐ No
									☐ Yes ☐ No
									☐ Yes ☐ No

I authorize any payroll deductions required for the coverage and recognize that I must notify Highmark of any changes in my dependents or their status.

To the best of my knowledge and belief, the information provided on this application is true and complete.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person and employer to criminal and civil penalties.

I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and that Highmark may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand and agree that a copy of Highmark's Notice of Privacy Practices is available on Highmark's web site, or from the Highmark Privacy Office.

Print Employee/Contract Holder Name

Print Employer/Group Name

Employee/Contract Holder Signature

Date

For New Group business: Please send all new business materials (Small Group Business Application, Enrollment/Waiver Forms and all supporting documentation) to the appropriate Highmark Small Group Sales Contact.

For ongoing enrollment of adding new employees/contract holders/dependents to an existing group, please fax/send Enrollment/Waiver Forms to one of the following addresses:

Fax (800) 290-3301

https://www.enrollmentonline.highmark.com

Membership Department
P.O. Box 535193
Pittsburgh, PA 15253-5193

To find more information about our benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to Discover.Highmark.com/QualityAssurance or for a paper copy, call 1-855-873-4106.

Highmark prohibits discrimination on the basis of race, color, national origin, age, disability, ancestry, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefits determinations.

3831

UNITED CONCORDIA®

(Please specify)

- O Concordia Access
- O Concordia Choice
- O Concordia Preferred

- O Cancel All Coverage (Employee & All Dependents)
- O Cancel Dependent(s) Only

Provider (umber (DHMO only)

- O Change Name
- O To COBRA Group
- O Other_____

SECTION C: EMPLOYEE INFORMATION

Identification Number (Social Security Number) | Date of Birth (mm/dd/yyyy) | Sex | Original Employment Date (mm/dd/yyyy)

First Name | M.I. | Last Name

Home Address

City | State | ZIP Code

children, complete and attach an additional form. If dependent children listed in this section are disabled or full-time student age 19 or over, please see your group administrator for a Dependent Certification Form, which should be completed and returned with the Dental Enrollment Form.

#1

First Name | M.I. | Last Name

Dependent Identification Number (Social Security Number) | Date of Birth (mm/dd/yyyy) | Sex | Provider Number (DHMO only)

#2

First Name | M.I. | Last Name

#3

Dependent Identification Number (Social Security Number) | Date of Birth (mm/dd/yyyy) | Sex | Provider Number (DHMO only)

First Name | M.I. | Last Name

Dependent Identification Number (Social Security Number) | Date of Birth (mm/dd/yyyy)

First Name | M.I. | Last Name

#5

Dependent Identification Number (Social Security Number) | Date of Birth (mm/dd/yyyy) | Sex | Provider Number (DHMO only)

First Name | M.I. | Last Name

#6

Dependent | Sex | Provider Number (DHMO only)

First Name | M.I. | Last Name

If your answer is yes, please complete the following information.

Insurance Company

Effective Date (mm/dd/yyyy)

I represent that all information supplied in this application is true and correct. I understand that if I, or any company or other person, files an application for insurance containing any false information concerning any fact material thereto, I may not establish a claim

Employee Signature | Phone Number | Email Address | Date

570-941-7767

Employer Signature | Phone Number | Date

Provider Availability

does not have regulatory approval.

- Domestic partner coverage is not permitted in Idaho.

State Mandated Provisions

CA: California law prohibits an HIV test from being required

obtaining health insurance coverage.

of an application containing any false, incomplete or

benefits unless contained in writing and signed by the Policyholder.

KS: Any person who knowingly and with intent to defraud

insurance act which may be a crime.

LA: Any person who knowingly presents

claim for payment of a loss or benefit or knowingly

is guilty of a crime and may be subject to fines and

be binding upon both you and the company.

person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NY: Any person who knowingly and with intent to defraud any

false information, or conceals for the purpose of misleading,

a fraudulent insurance act, which is a crime and shall also be

insurance act which may be a crime.

OR: Contestability is limited to two years as stated in the Group Policy.

subject to arbitration as an alternative to court action pursuant

jurisdiction.

VA: Any person who within the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

United Concordia operates as a wholly owned subsidiary under the name listed below in the following states:

- United Concordia Dental Plans, Inc.—DC, MD, NJ
- United Concordia Dental Plans of California, Inc.—CA
- United Concordia Dental Plans of the Midwest, Inc.—MI, MO, OH
- United Concordia Insurance Company—CT, FL, GA, HI, IA, ID, IN, KS, LA, MA, MD, ME, MI, MN, MS, MT, NE,
- United Concordia Insurance Company of New York—NY

MEDICAL/DENTAL ENROLLMENT OPTION FORM

I. Premium Conversion Plan

125 participant:

a. [ ] I wish to participate in the Premium Conversion Plan and make contributions toward the cost of medical and dental insurance premiums with ____ tax dollars. I understand that my compensation will be reduced while this election is in effect and the amount of the reduction will be the amount of the cost of the insurance premiums.

125 non-participant:

b. [ ] I decline participation in the Premium Conversion Plan. I understand that payment of any medical and dental insurance premiums will be with after-tax dollars.

II. Opt-Out Plan

[ ] I wish to waive medical and dental insurance coverage which the University provides to employees and spouses and dependents.

and hereby certify that medical insurance is provided elsewhere. I understand that except for a life event as defined by the IRS, I will only be allowed to opt back into coverage during the annual open enrollment period.

Name:_____

Date:_____

Signature:_____

TRANSAMERICA®

Retirement Solutions

Beneficiary Designation

Instructions

To designate a beneficiary or to change your existing beneficiary designation on an annuity plan, complete all applicable sections of this form, obtain [illegible] Plan Administrator. To confirm if your plan is an annuity plan please see your Plan Administrator or call Transamerica at 800-755-5801. For further information, please refer to the Qualified Pre-Retirement Survivor Annuity Explanation.

☐ Initial Designation ☐ Change of Designation

Section A. Employer Information

Company/Employer Name

Contract/Account No. | Affiliate No. | Division No.

Section B. Personal Information

Social Security No. | Date of Birth (mm/dd/yyyy)

First Name/Middle Initial | Last Name

Mailing Address

City | State | Zip Code

Phone No. | Ext.

E-mail Address

Marital Status: ☐ Married ☐ Single/Divorced

Section C. Primary Beneficiary Designation - You must complete this section

This designation will apply to the account number above. You must designate a specific percentage for each beneficiary. Shares must be whole [illegible] usually assume multiple beneficiaries. If the named beneficiary is a trust, please specify the name and date of the trust, and the name of the trustee.

Note: Share of benefits must total 100% for primary beneficiaries. If additional space is needed to designate multiple beneficiaries, complete the Supplemental Beneficiary Designation page.

[illegible] Share (whole percentages only) | Relationship

Last Name | First Name/Middle Initial | Date of Birth (mm/dd/yyyy)

Social Security No.

Mailing Address

City | State | Zip Code

Primary Beneficiary Designation (continued)

Share of Benefits: ____ % (whole percentages only) Relationship ____

Last Name ____ Date of Birth (mm/dd/yyyy) ____

[illegible]

Mailing Address ____

City ____ State ____ Zip Code ____

Section D. Contingent Beneficiary(ies) - Will receive benefits if no primary beneficiary is living at the time of your death

[illegible] If additional space is needed to designate multiple beneficiaries, complete *the Supplemental Beneficiary Designation page.*

Share of Benefits: ____ % (whole percentages only) Relationship ____

[illegible]

Social Security No. ____

Mailing Address ____

City ____ State ____ Zip Code ____

Share of Benefits: ____ % (whole percentages only) Relationship ____

Date of Birth (mm/dd/yyyy) ____

Social Security No. ____

Mailing Address ____

City ____ State ____ Zip Code ____

Section E. Waiver of Qualified Pre-Retirement Survivor Benefit (for married participants if spouse is not primary beneficiary)

[illegible] pre-retirement survivor annuity death benefit coverage for my spouse. Instead, I designate the above beneficiary(ies) to receive all or a portion of the benefits upon my death.

X_____ X_____

Participant Signature Date

Section F. Spousal Consent (if spouse is not primary beneficiary)

[illegible] pre-retirement survivor annuity death benefit coverage. I understand [illegible]

[illegible]

X_____ X_____

Spouse Signature Date

WITNESSED

X_____ X_____

Plan Administrator or Notary Public Signature and Stamp/Seal Date

[illegible]

I certify that the information provided on this form is correct and complete.

X_____ X_____

Participant Signature Date

X_____ X_____

Print Name Social Security Number

Section H. Plan Administrator Signature

I certify that the information provided [illegible]

X_____ X_____

Plan Administrator Signature Date

Supplemental Beneficiary Designations

Social Security No.

First Name/Middle Initial | Last Name

Please allocate total 100% for primary beneficiaries (will receive benefits in the event of your death) AND 100% for contingent beneficiaries (will receive benefits if no primary beneficiary is living at the time of your death).

☐ Primary Beneficiary ☐ Contingent Beneficiary

Share of Benefits: % (whole percentages only) | Relationship

Last Name | Date of Birth (mm/dd/yyyy)

First Name/Middle Initial | Social Security No.

Mailing Address

City | State | Zip Code

☐ Primary Beneficiary ☐ Contingent Beneficiary

Share of Benefits: % (whole percentages only) | Relationship

Last Name | Date of Birth (mm/dd/yyyy)

First Name/Middle Initial

Mailing Address

City | State | Zip Code

TIAA CREF

BENEFICIARY DESIGNATION FORM

Call 800 842-2252
Monday - Friday
8 a.m. - 10 p.m. (ET)

at 800 842-2252.

Did you know that incomplete information can make it difficult for us to find your beneficiaries?

Selecting a Beneficiary

Spousal Rights to Annuity Death Benefits

AZ, CA, ID, LA, NV, NM, TX, WA and WI.

or tax-deferred annuity plan covered by any of the following: ERISA or your plan's spousal policy. If you name

other beneficiary(ies) listed as primary.

TIAA CREF

Financial Services

BENEFICIARY DESIGNATION FORM

human resources administrator for any

How to waive a preretirement survivor death benefit?

Waiver form. A Notary Public or Plan Representative must witness your spouse signing and dating the spousal

complete another Spousal Waiver once you attain age 35.

TIAA CREF

Print in upper case using black or dark blue ink and provide all information requested.

To help avoid incorrect interpretation or delays, please be sure that all handwritten information is legible.

1. PROVIDE YOUR INFORMATION

First Name

Middle Initial

Last Name

Suffix

Social Security Number/
Taxpayer Identification Number

Date of Birth (mm/dd/yyyy)

Address

City

State

Zip Code

Contact Telephone Number

Extension

Please note: TIAA-CREF contractual rules state that we will recordkeep beneficiary(ies) at an individual-contract level, not a plan-based level.

2. DESIGNATION TYPE (CHOOSE ONE)

Please check the box to indicate a new designation request or an update to an existing designation.

☐ New designation

NOTE: If you select this option, it will completely replace any prior designations for each of your accounts named in Section 3.

☐ Update to an existing beneficiary(ies)

(For Name changes, Address changes, update SSN, etc.)

Check the first box if you want the same beneficiary designation(s) for all your applicable TIAA-CREF annuity contracts. Check the second box if you want the beneficiary designation to apply to specific contracts.

NOTE: Designations can only be at the contract level. Plan-based designations are not acceptable.

3. APPLICABLE CONTRACTS

This beneficiary designation applies to:

☐ All my applicable TIAA-CREF pension, annuity and IRA contracts

☐ Only the TIAA-CREF pension, annuity or IRA contract set(s) indicated below:

TIAA Number	CREF Number
TIAA Number	CREF Number
TIAA Number	CREF Number

If you have TIAA-CREF please visit us at tiaa-cref.org or call us at 800 842-2252.

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BENEFICIARY DESIGNATION FORM

A beneficiary can be an individual, an institution, a testamentary trust,* or beneficiaries receive

beneficiaries. If none of the beneficiaries are death, the benefits go

acceptable IF we are provided the date the will, under that Testamentary Trust, was issued.

If your percentage does not equal 100% or is not provided, we will prorate the unspecified percentage equally.

**If you check 'per

you, the monies which would have been paid to that beneficiary will be

among his/her children

ately to the remaining beneficiaries in that class

other beneficiaries, we

See Provisions at end of

4. CHOOSING YOUR PRIMARY BENEFICIARY

To the person I am legally married to at the time of my death

OR

2. PRIMARY BENEFICIARY

First Name Middle Initial

Address

City State Zip Code

Contact Telephone Number Country Gender

Social Security Number/ Date of Birth/Date of Trust/

Per stirpes**

2. PRIMARY BENEFICIARY

Last Name Percentage

Address

City State Zip Code

Contact Telephone Number Country Gender

Social Security Number/ Date of Birth/Date of Trust/

Per stirpes**

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If you have more than one primary beneficiary, benefits will be divided equally among the beneficiaries unless you specify the percentage. The percentages for all of

Will' as a designation. Testamentary trusts are

the Will, under that Testamentary Trust was issued

If you check "per

would have been paid to that beneficiary will be divided proportionately among his/her children (if any). If there are no

beneficiary their portion will be paid proportion-

In the event there are no other beneficiaries, we

Address

City

State

Zip Code

Contact Telephone Number

Country

Gender

Social Security Number/ Taxpayer Identification Number

Date of Birth/Date of Trust/ Issue Date of Will (mm/dd/yyyy)

Relationship

☐ Per stirpes*

4. PRIMARY BENEFICIARY

First Name

Last Name

Address

City

State

Zip Code

Contact Telephone Number

Country

Gender

Social Security Number/ Taxpayer Identification Number

Date of Birth/Date of Trust/ Issue Date of Will (mm/dd/yyyy)

Relationship

☐ Per stirpes*

☐ Check this box and attach a signed letter, to list additional primary and/or contingent beneficiaries, and provide additional instructions. Please include your contract numbers.

equally among the living beneficiaries unless you specify the percentage. The percentages for all of the contingent beneficiaries must total 100%.

TIAA cannot accept a 'will' as a designation.

provided the date

*If you check 'per stirpes' and the named

to that beneficiary will be divided proportionately among his/her children

living children for that beneficiary their portion will be paid proportionately to the remaining

In the event there are no other beneficiaries, we

First Name | Middle Initial

Last Name | Percentage

Address

City | State | Zip Code

Social Security Number/ | Date of Birth/Date of Trust/ | F | M

Per stirpes*

First Name | Middle Initial

Address

City | State | Zip Code

Taxpayer Identification Number | Issue Date of Will (mm/dd/yyyy) | Relationship

Per stirpes*

CONTINUED ON NEXT PAGE

TIAA CREF
Financial Services

BENEFICIARY DESIGNATION FORM

If you have more than one contingent beneficiary, benefits will be divided equally among the living

The percentages for

total 100%.

TIAA cannot accept a will as a designation. Testamentary trusts are acceptable if we are

*If you check 'per you, the monies which would have been paid to that beneficiary will be divided proportionately among his/her children (if any). If there are no living children for that beneficiary their portion will be paid proportion-

In the event there are no other beneficiaries, we will pay your Estate.

3. CONTINGENT BENEFICIARY

First Name | Middle Initial

Address

City | State | Zip Code

Social Security Number/ Taxpayer Identification Number | Date of Birth/Date of Trust/ Issue Date of Will (mm/dd/yyyy) | Relationship

Per stirpes*

4. CONTINGENT BENEFICIARY

First Name | Middle Initial

Last Name | Percentage

Address

City | State | Zip Code

Contact Telephone Number | Country | Gender

Social Security Number | Date of Birth/Date of Trust

/ /

Per stirpes*

Please provide your signature and the date.

6. YOUR SIGNATURE

I, the undersigned, agree that:

- All prior beneficiary designations previously requested and any benefits due by reason of my death will be payable to the beneficiary(ies) named on this form, if I elected option 1 in Section 2.
- I understand that this form is subject to all of the terms and conditions of the pension, annuity and IRA
- I reserve the right to make further changes to my beneficiary designations.
- If you named an irrevocable beneficiary, your annuity partner will be unable to change the designation at any time.
- to those active as of the date this form is accepted by TIAA-CREF.
- I understand that if I elect an option of any accumulation for which this designation applies is subject to Spousal Consent under plan or ERISA rules, my spouse must complete a spousal waiver form.
- I understand that if I elect [illegible] will be paid as outlined in this form.
- I understand and agree to the changes and updates I made on this form.

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BENEFICIARY DESIGNATION FORM

7. ADDITIONAL REQUIREMENTS BASED ON MARITAL STATUS

The Employee Retirement Income Security Act of 1974 (ERISA) provides rights to the spouse of a participant in a retirement plan subject to the law. Some Non-ERISA plans may also require that we pay your entire 100% to a surviving spouse at death.

NOTE: Due to Plan Provisions of Employee Retirement Income Security Act (ERISA)

7A. IF YOU ARE SINGLE, COMPLETE THIS SECTION

Check the box if you are not married

☐ I am not married.

7B. IF YOU ARE MARRIED

If you are married, your spouse as a primary beneficiary for at least 50% of the benefit of the percentage required by ERISA or your plan, your spouse must complete this section in front of a Notary Public or your current employer's plan representative.

In order to ensure that your spouse has seen your intentions and can attest that they fully agree to waive their [illegible] must be the same or a later date than you signed in Section 6.

Consent by Spouse (Must Be Completed by Your Spouse and Witnessed)

I understand that I may be entitled to a death benefit under spousal consent law. I recognize that [illegible] paid to the beneficiaries as designated on this form.

Spouse, This verification will be completed prior to benefits being paid/ settled to any beneficiary.

First Name (Please print) | Last Name (Please print)

Your Signature | Today's Date (mm/dd/yyyy) / / 20

NOTARY PUBLIC CERTIFICATION

State | County | / / 20

[illegible] foregoing instrument and he/she acknowledged to me that he/she executed the same.

Notary Public's Signature | Today's Date (mm/dd/yyyy) / / 20

[illegible] | In this case, the Notary Public must provide his/her [illegible] number and the date his commission expires.

MASSACHUSETTS ONLY: ☐ Testimony of a credible witness. | Provide the notarial seal if outside New York state.

PLAN REPRESENTATIVE CERTIFICATION

[illegible] Signature | / / 20

Plan Representative's Name (please print) | Title

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Financial Services

BENEFICIARY DESIGNATION FORM

Please review carefully to ensure your application is complete; failure to do so may delay processing.

YOUR CHECKLIST

- ☐ Provide all the personal information requested and choose your beneficiaries.
- ☐ Complete the "Additional Requirements Based on Marital Status" section. If you are single, complete
- ☐ front of a Notary Public or your current employer's plan representative.

Original documents are required. Faxes cannot be accepted.

PLEASE RETURN COMPLETED FORM TO:

TIAA-CREF

TIAA-CREF

TIAA CREF
Financial Services

BENEFICIARY DESIGNATION FORM

BENEFICIARY PROVISIONS

1. Effectiveness

This Designation of Beneficiary is effective for each annuity contract and certificate listed by number or by definition of contracts as stated in the Annuity Numbers section. If the beneficiary designations are satisfactory to TIAA-CREF's standards and the designations are accepted by TIAA-CREF, the designations

2. Immediate Annuity under a Two-Life Option

Your confirmation will display this change.

3. Order of Payment and Division of Benefits

a. Unless otherwise stated, if you (or the last surviving annuitant under a Two-Life Annuity) any benefits due will be paid to a beneficiary if he or she is then living. If a class of beneficiaries

proportions stated. If a beneficiary predeceases you (or the last surviving annuitant under a Two-Life

annuitant under a Two-Life Annuity).

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Financial Services

BENEFICIARY DESIGNATION FORM

ADDITIONAL PROVISIONS

Provision: "Per stirpes" provision applied to a beneficiary means that if you check 'per stirpes' and the named beneficiary predeceases you, the monies which would have been paid to that beneficiary will be divided proportionately among his/her children (if any). If there are no living children for that beneficiary, [illegible] no other beneficiaries, we will pay your Estate.

Example:

John Doe – your son with a 100% designation per stirpes

Jane Doe – your daughter with a 100% designation per stirpes

[illegible] will be paid to his children equally. If John has no children, his share will then be paid to Jane. If both John and Jane predecease you and there are no children, we will pay the [illegible] in the absence of any contingent beneficiaries, we will pay your Estate.

4. If a Testamentary Trust is Designated as Beneficiary:

a. TIAA-CREF will not accept or be obliged to inquire into the terms of any will or of any trust affecting the annuity contract/certificate or its death benefit and shall not be charged with knowledge of terms thereof.

b. TIAA-CREF will accept a testamentary trust if you give us the proper name of the trust in the designation. A designation of Will is not acceptable.

c. If benefits become payable to a testamentary trust and (i) the will is not presented for probate within 90 days following the date of your death (or the death of the last surviving annuitant in a Two-Life Annuity), or (ii) the will has been presented for probate within the aforesaid 90 days and no qualified trustee named therein will serve, or (iii) if evidence is furnished and is satisfactory to TIAA-CREF [illegible] surviving annuitant in a Two-Life Annuity), or (iii) if evidence is furnished and is satisfactory to TIAA-CREF [illegible] surviving annuitant).

d. If benefits become payable to an inter vivos trust and (i) the trust agreement is not in effect, or (ii) [illegible] otherwise to your estate (or to the estate of the last surviving annuitant).

e. Payment to, and receipt by, said trustee, said successor beneficiary(ies) or said estate, as provided [illegible] TIAA-CREF shall have no obligations as to the application of funds so paid and shall, in all dealings [illegible] release or waiver of interest, be fully protected against the claims or demands of any other person(s).

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TELEFUNDS BENEFICIARY DESIGNATION FORM

FRAUD WARNING

[illegible] SPECIFIC NOTICE/WARNING REQUIRED BY MANY STATES

This notice/warning does not apply in New York.

[illegible] for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties [illegible] including commitment in prison and civil penalties.

Colorado residents, please note: Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Virginia and Washington, DC residents, please note: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.