Retiree Name: _____ Analyst: _____ Date: _____

FINAL RETIREMENT FORMS CHECKLIST

1. _____ **AACO Retirement Application w/Election updated**
2. _____ **Federal Tax Withholding**
3. _____ **Maryland Tax Withholding**
4. _____ **Pension Beneficiary**
5. _____ **AACO Reemployment After Retirement Rules**
6. _____ **Direct Deposit** _____ **Voided check/Savings Slip included**
7. _____ **AACO Health Benefits Enrollment Form**
8. _____ **Create Excel Health/Life Ins. form (for retiree signature)**
9. _____ **Life Insurance Beneficiary Form**
10. _____ **Disability Waiver of Life Insurance Premium (Service only)**
11. _____ **457 Deferred Comp (contact T.R.P. directly)**
12. _____ **FSA – Flexible Spending Account (must use or lose)**
13. _____ **DROP Lump sum W/D form (front only)**
14. _____ **DROP at a Glance (discuss)**
15. _____ **Schedule of final check (final payroll, leave payout)**
16. _____ **Employee Exit Interview (Voluntary)**

NOTES: _____

_____

_____

CHECK DATES FOR RETIREMENT:

_____: **First Retirement check (will NOT be direct deposit)**
DROP Non-Taxable: _____
DROP Taxable Rollover: _____

_____: **Final paycheck for regular work days**

_____: **Final leave payout calculated (not before this date)**

NOTE: **If Final Leave payout is deferred to TRP, it will NOT have taxes withheld and amount deferred will NOT be included as wages on your W2.
****If Final leave payout is paid to you it will be taxed as regular income in year it is paid.**

I want to defer _____% of my A/L to my TRP 457 Deferred Comp Acct

I want to defer _____% of my D/L to my TRP 457 Deferred Comp Acct

I want to defer _____% of my COMP HRS to my TRP 457 Deferred Comp Acct

I want to defer _____% of my Floater Days to my TRP 457 Deferred Comp Acct

_____ _____
RETIREE SIGNATURE DATE

ANNE ARUNDEL COUNTY
RETIREMENT APPLICATION

RETIREMENT EFFECTIVE DATE: _____

APPLICANT INFORMATION email address: _____

_____ _____ _____
MEMBER NAME SOCIAL SECURITY NUMBER BIRTH

MARRIED Y N

_____
PHONE NUMBER

_____ _____ _____ _____
ADDRESS CITY STATE ZIP

SELECT PLAN TYPE:

☐ EMPLOYEE ☐ TIER 1 ☐ TIER 2

☐ DETENTION OFFICERS & SHERIFFS ☐ DROP Entry ☐ DROP Exit Date_____

☐ FIRE ☐ POLICE ☐ DROP

I HEREBY MAKE APPLICATION FOR THE FOLLOWING RETIREMENT TYPE *(Please select one)*:

☐ Normal ☐ Service Connected Disability

☐ Early ☐ Non-Service Connected Disability

I HEREBY IRREVOCABLY ELECT THE FOLLOWING BENEFIT PAYMENT OPTION *(Please select one)*:

☐ PUBLIC SAFETY (Fire/Police) NORMAL PENSION OPTION MARRIED Y N

☐ NORMAL PENSION OPTION

☐ JOINT AND _____% SURVIVOR OPTION

☐ JOINT AND _____% SURVIVOR WITH POP-UP OPTION

☐ SOCIAL SECURITY ADJUSTMENT OPTION AT AGE 62

PLEASE NOTE: NOT ALL OPTIONS ARE AVAILABLE IN ALL PLANS

I hereby elect as my Joint Annuitant: _____
NAME

_____ Proof of Marriage Submitted ☐
SOCIAL SECURITY NUMBER

_____ Proof of Age Submitted ☐
DATE OF BIRTH

I certify that the information on this form is true and correct to the best of my knowledge.

_____ _____
MEMBER SIGNATURE DATE

Form **W-4P**

Department of the Treasury
Internal Revenue Service

Withholding Certificate for Periodic Pension or Annuity Payments

Give Form W-4P to the payer of your pension or annuity payments.

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

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

Address

City or town, state, and ZIP code

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See pages 2 and 3 for more information on each step and how to elect to have no federal income tax withheld (if permitted).

Step 2: Income From a Job and/or Multiple Pensions/ Annuities (Including a Spouse's Job/ Pension/ Annuity)

Complete this step if you (1) have income from a job or more than one pension/annuity, or (2) are married filing jointly and your spouse receives income from a job or a pension/annuity. **See page 2 for examples on how to complete Step 2.**

Do **only one** of the following.

(a) Reserved for future use.

(b) Complete the items below.

(i) If you (and/or your spouse) have one or more jobs, then enter the total taxable annual pay from all jobs, plus any income entered on Form W-4, Step 4(a), for the jobs less the deductions entered on Form W-4, Step 4(b), for the jobs. Otherwise, enter "-0-" . . . $

(ii) If you (and/or your spouse) have any other pensions/annuities that pay less annually than this one, then enter the total annual taxable payments from all lower-paying pensions/ annuities. Otherwise, enter "-0-" . . . . . $

(iii) Add the amounts from items (i) and (ii) and enter the **total** here . . . . . $

TIP: To be accurate, submit a new Form W-4P for all other pensions/annuities if you haven't updated your withholding since 2021 or this is a new pension/annuity that pays less than the other(s). Submit a new Form W-4 for your job(s) if you have not updated your withholding since 2019. If you have self-employment income, see page 2.

Complete Steps 3–4(b) on this form only if (b)(i) is blank **and** this pension/annuity pays the most annually. Otherwise, do not complete Steps 3–4(b) on this form.

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

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

Multiply the number of other dependents by $500 . . . . . $

Add other credits, such as foreign tax credit and education tax credits $

Add the amounts for qualifying children, other dependents, and other credits and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs or pension/annuity payments). If you want tax withheld on other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, taxable social security, and dividends . **4(a)** $

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

(c) Extra withholding. Enter any additional tax you want withheld from **each payment** . **4(c)** $

Step 5: Sign Here

Your signature (This form is not valid unless you sign it.) **Date**

FORM
MW 507P

Comptroller of Maryland
Revenue Administration Division
Annapolis, Maryland 21411-0001

Maryland Income Tax Withholding for Annuity, Sick Pay and Retirement Distributions

Type or print full name	Social security number
Home address (number & street)	
City, state, and zip code	
A. Contract claim or identification number	
B. Enter the amount withheld from each annuity, sick pay or retirement distribution payment	$

I request voluntary income tax withholding from any annuity, sick pay or retirement distribution payments as authorized by Section 10-907(b) of the Tax-General Article of the Annotated Code of Maryland.

COM/RAD-044 (Rev. 01-08) 08-49 (Signature) (Date)

Instructions

Who may file – Any recipient of an annuity, sick pay or retirement distribution payment may file this form to have Maryland income tax withheld from each payment. However, the annuity must be payable over a period longer than one year.

Sick pay – The term "sick pay" means any amount which is paid to an employee pursuant to a plan to which the employer is a party and constitutes remuneration or a payment in lieu of remuneration for any period during which the employee is temporarily absent from work on account of sickness or personal injuries.

Where and how to file – *File this form with the payer of your annuity, sick payment or retirement distribution.* Enter in item B of page 1, the whole dollar amount that you wish withheld from each annuity or sick pay payment. The amount must not be less than $5 a month for annuities and retirement distributions and at least $2 per daily payment in the case of sick pay.

You may find it convenient to request an amount to be withheld which will reduce your year-end tax balance on your individual Maryland tax return to an amount of $500 or less and thus avoid having to file an individual Declaration of Estimated Tax (Form 502D or 502 DEP).

You may use the worksheet provided with the declaration as a guide in estimating your income tax liability.

Duration of withholding request – Your request for voluntary withholding will remain in effect until you terminate it.

How to terminate a withholding request – You may terminate, at any time, your request for voluntary withholding by giving your payers a written termination notice.

Statement of income tax withheld – At the close of the year, your payer will furnish you with a Form 1099 or other appropriate form showing the gross amount of annuity or sick pay payments and the total amount deducted and withheld as tax during the calendar year.

Do not mail this form to the Maryland Revenue Administration Division

ANNE ARUNDEL COUNTY
PENSION
BENEFICIARY FORM
RETIREE

PARTICIPANT'S NAME _____ SOCIAL SECURITY # _____

(___) _____ (___) _____ _____

PHONE NUMBER CELL PHONE NUMBER OTHER

PRIMARY BENEFICIARY

NAME (1)	SS#	BIRTH DATE	RELATIONSHIP	PHONE #
ADDRESS		CITY	STATE	ZIP
NAME (2)	SS#	BIRTH DATE	RELATIONSHIP	PHONE #
ADDRESS		CITY	STATE	ZIP

CONTINGENT BENEFICIARY

NAME (1)	SS#	BIRTH DATE	RELATIONSHIP	PHONE #
ADDRESS		CITY	STATE	ZIP
NAME (2)	SS#	BIRTH DATE	RELATIONSHIP	PHONE #
ADDRESS		CITY	STATE	ZIP

You may change your beneficiary at any time by contacting the Office of Personnel or you may request a form by calling the Forms Line at (410) 222-7590. The death benefit will be divided equally among all designated primary beneficiaries unless otherwise specified.

The most recent dated beneficiary designation form takes precedence.

SIGNATURE _____ DATE _____

☐ **Please check if additional form was needed**

REVISED 5/10

RETURN TO MS 9101 OR MAIL TO P.O. BOX 6675, ANNAPOLIS, MD 21401

ANNE ARUNDEL COUNTY
MARYLAND

ANNE ARUNDEL COUNTY GOVERNMENT
RETIREE
Direct Deposit Authorization Form

RETIREE'S NAME _____ SOCIAL SECURITY NO. _____ HOME PHONE # _____

1. PRIMARY ACCOUNT (select checking or savings)

☐ CHECKING
☐ SAVINGS

BANK ROUTING NUMBER

BANK NAME

ACCOUNT NUMBER

MUST BE A FULL DEPOSIT

2. SECONDARY ACCOUNT - OPTIONAL (select checking or savings)

☐ CHECKING
☐ SAVINGS

BANK ROUTING NUMBER

BANK NAME

ACCOUNT NUMBER

A PORTION OF YOUR FULL DEPOSIT
$

I authorize you and the bank listed above to deposit my net pay automatically to my account each payday. If funds to which I am not entitled are deposited to my account, I authorize you to direct the bank to return said funds. This authority will remain in effect until I have cancelled it in writing.

_____ _____
RETIREE'S SIGNATURE *DATE*

DO NOT WRITE BELOW THIS LINE ** FOR PAYROLL USE ONLY***

PRIMARY FILE # I.D. #

1. DED CODE	*ABA# IF DIFFERENT*	*ACCOUNT# IF DIFFERENT*	*FULL DEPOSIT*	*PRE-NOTE Y OR N*
			X	

SECONDARY

2. DED CODE	*ABA# IF DIFFERENT*	*ACCOUNT# IF DIFFERENT*	*FULL DEPOSIT*	*PRE-NOTE Y OR N*

_____ _____
PROCESSED BY *DATE KEYED*

( ) WE COULD NOT PROCESS THIS REQUEST FOR THE FOLLOWING REASONS:

_____

_____

*****INSTRUCTIONS ARE ON THE BACK*****

Pension/Benefits: 410-222-7595 www.aacounty.org Mail Stop: 9101

* Fax: 410-222-4512 Employee Benefits Division – P.O. Box 6675 – Annapolis, MD 21401 Out of Area: 800-870-6169

INSTRUCTIONS:

1. Complete all applicable items down to signature line and sign the form.
2. Attach a voided or a copy of your personal check.
3. If your request is to a Savings Account, please provide a copy of any account verification your bank may have supplied.
4. Mail completed form to the address below.
5. Your form must be received by the 15th of the month in order to be processed the following month.
6. Once your request is processed, your following benefit check will be a live check and will be mailed to the address on file in the Benefits' office.
7. All subsequent checks will go to your new account.

Sample:

a. January 15 – request is processed
b. February 1 – live check
c. March 1 – new direct information will take place

Revised 11/30/06

Pension/Benefits: 410-222-7595 www.aacounty.org Mail Stop: 9101

* Fax: 410-222-4512 Employee Benefits Division – P.O. Box 6675 – Annapolis, MD 21401 Out of Area: 800-870-6169

ANNE ARUNDEL COUNTY
MARYLAND

Reemployment After Retirement

As a retiree from the County, it is important that you understand the consequences of reemployment after you retire. In some instances there may be a limitation as to what you may earn before it affects your pension benefit. In other instances there may be a restriction imposed by the Internal Revenue Service (IRS).

Reemployment with a County Government participating employer:

Anne Arundel County policy requires that there be a minimum 30-day break in employment between the person's date of retirement with the County and their subsequent date of re-hire. This break applies to ALL retired County employees regardless of their age at their date of retirement or employment classification upon re-hire.

Tax Consequences

Internal Revenue Service (IRS) guidelines prohibit distributions from a qualified pension plan to participants who are actively employed in either a full-time or part-time position with an employer covered by the plan. This prohibition extends to participants under the age of 59 ½ years who are re-employed after retirement without a bona fide break in service. The IRS may impose a 10% penalty on your retirement benefit if you violate the prohibition.

Consequently, you must be removed from the County payroll for at least 30 days before being reemployed by the County. Also, your decision to retire must not be conditioned upon an offer of re-employment. In fact, no offer of re-employment should be discussed by you and your employer prior to retirement.

Pension Earnings Offset

If you are reemployed with an Anne Arundel County Government employer after you retire, certain types of employment are subject to an earnings limit and your retirement benefit may be reduced by $1.00 for every $2.00 you earn as an employee. Prior to accepting employment with the County, you should contact the Benefits Office to discuss any potential impact on your retirement allowance.

Exceptions to the Pension Earnings Offset

Exceptions to the earnings offset applied if the employee is retired from the County as:

A classified employee and is *reemployed* by the County as:

1. An exempt employee under §802(a)(14) of the Charter; which would be a person assigned to an hourly rate position for temporary help, provided that the person is not compensated for more than 1500 hours per calendar year;
   This does not apply to DROP retirees covered under IAFF or Battalion Chiefs at retirement _____

Revised 12/13/2022

2. An exempt employee under §802(a)(17) of the Charter; which would be any person who is paid in whole or in part with State or Federal grant funds, regardless of the number of hours worked.
   This does not apply to DROP retirees covered under IAFF or Battalion Chiefs at retirement_____

3. An employee of the Sheriff in a position that requires the employee to be certified as a Police Officer by the Police Training Commission if the employee was certified as a Police Officer by the Police Training Commission at the time the employee retired;

4. An employee of the State's Attorney in a position that requires the employee to be certified as a Police Officer by the Police Training Commission if the employee was certified as a Police Officer by the Police Training Commission at the time the employee retired;

Or

Retired from the County as an exempt employee under the County Personnel Code **§ 6-2-101, 6-2-104, or 6-2-105** in a position that is *not exempt* from the provisions of the Fair Labor Standards Act, 29 U.S.C §207 et eq. and is reemployed by the County as an exempt employee under§802(a)(14) of the Charter, which would be a person assigned to an hourly rate position for temporary help, provided that the person is not compensated for more than 1500 hours per calendar year;

Reemployed by the private sector or a public sector employer OTHER THAN Anne Arundel County Government:

If you elected a normal or early service retirement and accept employment with the private sector or with a non-participating County Government employer, there are no restrictions. You will continue to receive your full monthly retirement benefit regardless of your employment income.

You should discuss specific circumstances with the Benefits Office to ensure that you make an informed decision regarding your retirement benefits and any offset that may be applicable.

Deferred Compensation 457(b) Plan:
If you return to employment in any capacity with Anne Arundel County Government, even as a contractual employee, you would **not** be permitted to take distributions from your Deferred Compensation account with T. Rowe Price during your period of employment. Distributions are only permitted upon Severance from Employment, or upon meeting the requirements for an In-Service Distribution under Article V of the Deferred Compensation Plan of Anne Arundel County, which are limited to the following:

1) Loan
2) Unforeseeable Emergency (Financial Hardship), or
3) If you have not contributed for at least two years and have a balance less than $5,000
4) You are 59 ½ or older
5) Qualified Birth or Adoptions

I have read and discussed the above information and understand the how reemployment may impact my pension earnings from the Anne Arundel County Retirement System.

_____ _____

ANNE ARUNDEL COUNTY MARYLAND

ANNE ARUNDEL COUNTY GOVERNMENT

Retiree Benefits Enrollment Form – 2024 Plan Year

Employee Information (Please Print)

Name: _____ SS #: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Gender: ___ Email Address: _____ Daytime Phone #: _____

Retirement Date: _____ Subsidy Code: _____

Health Care Election – Enter Coverage Elections(s) for 2024 plan year

HEALTH CARE ELECTION – ENTER NEW COVERAGE

Medical Plans

- ❒ Aetna Open Choice PPO
- ❒ Open Access Aetna Select HMO-EPO
- ❒ Aetna Medicare PPO ESA (**Attach copy of Medicare Card**)
- ❒ No Coverage

Dental Plans

- ❒ Cigna PPO (Core)
- ❒ Cigna PPO (Buy-Up)
- ❒ CIGNA DHMO

(I understand I must use a participating DHMO network dentist. _____ (initials)

- ❒ No Coverage

Vision Plan

- ❒ EyeMed Vision
- ❒ No Coverage

Medical Plan Coverage Level

- ❒ Individual
- ❒ Retiree & 1 Child
- ❒ Retiree & Spouse
- ❒ Family
- ❒ Split Option:

Retiree's Plan Name _____

Retiree's Spouse's Plan Name _____

Dental Plan Coverage Level

- ❒ Individual
- ❒ Retiree & 1 Child
- ❒ Retiree & Spouse
- ❒ Family

Vision Plan Coverage Level

- ❒ Individual
- ❒ Retiree & 1 Child
- ❒ Retiree & Spouse
- ❒ Family

Waive Insurance Coverage

I DECLINE INSURANCE COVERAGE IN THE FOLLOWING PLAN(S): ❒ MEDICAL ❒ DENTAL / VISION

I understand that if I am declining coverage now and decide at a later date to request coverage, I generally will have to wait until the next Open Enrollment period, unless I have a special enrollment right or I experience a qualifying family status change event and notify the Benefits Team within 31 days of that event. _____ **Initials (Attach proof of other insurance coverage)**

List All Eligible Individuals for Whom Coverage is requested; Attach copy of Marriage/Birth Certificate(s)

Name	Relationship S = Spouse C = Child	Social Security Number	Gender M/F	Birth Date

I hereby request enrollment as indicated above and authorize the corresponding deductions from my earnings. I understand that the above elections will remain in effect for the Plan Year noted on this Form and will continue in effect indefinitely beyond the Plan Year noted above unless I make an election change permitted under the Plan. I understand that I may change the above elections for a future Plan Year by submitting a new Enrollment Form during a later annual election period. I understand that I may change my elections for coverage during a Plan Year only under certain conditions, as described in the plan document. I understand that the cost of a benefit option that I have elected under the Plan may change from one Plan Year to the next and I agree that my payroll deductions will automatically change accordingly unless I submit a new Enrollment Form during the appropriate annual election period to change or terminate that coverage. I also understand that, during a Plan Year, if there is a change in the cost of a benefit option that I have elected, the County may automatically increase or decrease the amount of payroll deductions I am required to make per pay period to pay for that benefit option.

I understand that the County may modify my benefit elections if appropriate to insure that the Plan complies with the terms of the Plan and the requirements of applicable law and that, subject to the requirements of applicable law or any applicable insurance contract, the County retains the right to amend or terminate coverage under a benefit option. Also, I understand that the County may modify my elections for certain health benefit options if required to do so by a Medical Child Support Order that requires me to provide health coverage for a dependent.

If I am electing any coverage that provides for coverage for an individual as my spouse or dependent on a pre-tax basis, I understand that I am responsible for determining if my spouse or dependent is eligible to be treated as my spouse or dependent for federal tax purposes. I certify that any person for whom I am electing such coverage meets the applicable requirements for spouse or dependent coverage and I agree to inform the Benefits Team if that changes while my election of coverage is in effect. I understand that the County may also require proof that my spouse or dependent meets the Plan's eligibility requirements and retains the ultimate authority to determine any person's eligibility for coverage. I attest that the information provided above is complete and true to the best of my knowledge. I understand that false information provided on this Form will result in claim denial and possible termination of coverage.

Employee Signature: _____ Date: _____

FOR OFFICE OF PERSONNEL USE ONLY:

COVERAGE DATE: _____ HEALTH _____ RX: _____ DENTAL/VISION: _____

I2K: _____ OBA: _____ KEYED: _____ VERIFIED: _____

Rev: 8/2023 **RETURN THIS FORM TO THE OFFICE OF PERSONNEL, BENEFITS TEAM, MS 9101, 2660 RIVA ROAD, ANNAPOLIS, MD 21401 OR SEND VIA EMAIL TO: benefits_team@aacounty.org**

Anne Arundel County

RETIREE *Rate Schedule*

Effective – 1/1/24 to 12/31/24

At retiree cost share of 20% for medical; 100% for dental; 100% for vision.

This rate sheet reflects an employer retiree subsidy of 80%. For retirees who were not eligible for an early or normal retirement as of January 1, 2017, in accordance with Section 6-1-308(i) of the County Code, the employer subsidy rates vary and are based on years of service at the time of retirement. Please contact the Benefits Unit for specific subsidy rate information.

Retirees and spouses must enroll in Medicare at age 65 (or when you first become eligible) to avoid Medicare's late-enrollment penalties and to receive the maximum coverage available.

Plan & Coverage Level	Monthly Total Cost	Monthly County Cost	Monthly Retiree Cost
Aetna Open Choice PPO			
Individual	$955.98	$764.78	$191.20
Retiree and Child	$1,688.59	$1,350.87	$337.72
Retiree and Spouse	$2,025.24	$1,620.19	$405.05
Family	$2,630.01	$2,104.01	$526.00
Open Access Aetna Select HMO-EPO			
Individual	$747.72	$598.18	$149.54
Retiree and Child	$1,349.50	$1,079.60	$269.90
Retiree and Spouse	$1,601.61	$1,281.29	$320.32
Family	$2,067.63	$1,654.10	$413.53

MEDICARE ADVANTAGE
(For retiree or spouse eligible for medicare due to age or disability)

Aetna Medicare Advantage PPO ESA	Total Cost	County Cost	Retiree Cost
Individual	$554.93	$443.94	$110.99
Retiree and Spouse	$1,109.86	$887.88	$221.98

	CIGNA Dental DHMO *(DHMO-network dentist required)*	CIGNA Dental PPO (Core)	CIGNA Dental PPO (Buy-up)	Vision EyeMed
Individual	$19.53	$32.24	$49.84	$3.60
Retiree and Child	$39.06	$57.18	$88.42	$7.17
Retiree and Spouse	$49.62	$74.16	$114.66	$9.17
Family	$56.42	$82.41	$127.43	$10.41

Metropolitan Life Insurance Company

MetLife

Group Term Life Insurance Beneficiary Designation

Use this form to name the persons or entities you want to receive your life insurance proceeds after your death.

Things to know before you begin

- Completing this form replaces your existing beneficiary designations. Please provide details for **each** beneficiary, even if you have already given us this information in the past.
- Gather the name(s), date(s) of birth, Social Security/Tax ID number(s) and contact information for all of your beneficiaries.
- The beneficiaries you name on this form apply to your Group Term Life insurance coverage insured by MetLife.
- To name additional beneficiaries, attach a separate page. Provide the requested information including the beneficiary type *(primary or contingent)* and the % proceeds for each. Sign and date these page(s), making sure the date is the same as the date next to the signature on this form.
- Please complete and return **all** pages or we cannot record your choices.

If you make a mistake anywhere on this form, cross it out and initial it.

SECTION 1: About the Insured

First name	Middle name	Last name	
Date of birth *(mm/dd/yyyy)*	Social Security number	Phone number	
Address	City	State	ZIP
Employer name		Customer number	
Anne Arundel County Government		168573	

SECTION 2: About the Primary Beneficiaries

These parties are your first choice to receive the insurance proceeds after your death. If a primary beneficiary dies before you, we will divide their share(s) equally between the remaining primary beneficiaries.

- You must name at least one (1) primary beneficiary.
- Please check the box and complete the form fields for each beneficiary you name. Having accurate information for your beneficiaries ensures that we distribute the proceeds the way you want.
- Use the proceeds % field to tell us how you want us to distribute the proceeds. If you want a specific distribution, use whole numbers *(no fractions or decimals)* and make sure they *(and any listed on separate pages)* add up to 100%. To distribute them equally between your primary beneficiaries, leave **all** of the proceeds % fields blank.

About the Primary Beneficiaries *(continued)*

☐ **Individual**

A

First name	Middle name	Last name	
Address		Date of birth *(mm/dd/yyyy)*	Write in the % of proceeds assigned to this person _____%
City		State / ZIP	
Gender ☐M ☐F / Social Security number	Phone number	Relationship to Insured	

☐ **Individual**

B

First name	Middle name	Last name	
Address		Date of birth *(mm/dd/yyyy)*	Write in the % of proceeds assigned to this person _____%
City		State / ZIP	
Gender ☐M ☐F / Social Security number	Phone number	Relationship to Insured	

☐ **Individual**

C

First name	Middle name	Last name	
Address		Date of birth *(mm/dd/yyyy)*	Write in the % of proceeds assigned to this person _____%
City		State / ZIP	
Gender ☐M ☐F / Social Security number	Phone number	Relationship to Insured	

☐ **Your Estate –** If you name your Estate as a primary beneficiary, you cannot name a contingent beneficiary.

D Proceeds _____%

☐ **Testamentary Trust created in your Will –** The trust under your last Will and Testament as shall be admitted to probate.

E Proceeds _____%

☐ **Living *(Inter Vivos)* Trust –** See further instructions on page 4.

F Proceeds _____%

☐ **Charity/Organization –** List the charity or organization name and not an employee of the charity or organization. See further instructions on page 4.

G Proceeds _____%

Total proceeds for all primary beneficiaries *(A-G plus any listed on separate pages)* must equal 100%. **100%**

SECTION 3: About the Contingent Beneficiaries

Skip this section if you're not naming a contingent beneficiary or if you named your Estate as a primary beneficiary.

Contingent beneficiaries receive the insurance proceeds **only** if all of the primary beneficiaries are deceased at the time of your death. If a contingent beneficiary dies before you, we will divide their share(s) equally between the remaining contingent beneficiaries.

- Please check the box and complete the form fields for each beneficiary you name. Having accurate information for your beneficiaries ensures that we distribute the proceeds the way you want.
- Do not list the same person or entity as both a primary and a contingent beneficiary.
- Use the proceeds % field to tell us how you want us to distribute the proceeds. If you want a specific distribution, use whole numbers *(no fractions or decimals)* and make sure they *(and any listed on separate pages)* add up to 100%. To distribute them equally between your contingent beneficiaries, leave **all** of the proceeds % fields blank.

☐ **Individual**

First name	Middle name	Last name	**H**
Address		Date of birth *(mm/dd/yyyy)*	Write in the % of proceeds assigned to this person _____%
City		State / ZIP	
Gender ☐M ☐F / Social Security number	Phone number	Relationship to Insured	

☐ **Individual**

First name	Middle name	Last name	**I**
Address		Date of birth *(mm/dd/yyyy)*	Write in the % of proceeds assigned to this person _____%
City		State / ZIP	
Gender ☐M ☐F / Social Security number	Phone number	Relationship to Insured	

☐ **Your Estate** — **J** Proceeds _____%

☐ **Testamentary Trust created in your Will –** The trust under your last Will and Testament as shall be admitted to probate. — **K** Proceeds _____%

☐ **Living *(Inter Vivos)* Trust –** See further instructions on page 4. — **L** Proceeds _____%

☐ **Charity/Organization –** List the charity or organization name and not an employee of the charity or organization. See further instructions on page 4. — **M** Proceeds _____%

Total proceeds for all contingent beneficiaries *(H-M plus any listed on separate pages)* must equal 100%. — **100%**

SECTION 4: About your Trust/Charity/Organization Beneficiaries

Skip this section if you did not name a Living Trust or Charity/Organization as one of your beneficiaries. Otherwise, please provide the information requested below on a separate page. Make sure you include the type of beneficiary *(primary or contingent)* and that you sign and date these page(s).

Please include:

- Trust/Charity/Organization name
- Address
- Phone number
- Type of Beneficiary *(primary or contingent)*
- % of proceeds you are assigning to the Trust/Charity/Organization

Additional information required for Living *(Inter Vivos)* Trust(s):

- Trust date
- Trust Tax ID number
- Trustee first, middle and last name

SECTION 5: Signature required

By signing below, I hereby revoke any previous designations, and I designate the person, people, or entity named herein as beneficiaries.

☐ Check if you are completing and signing this form as agent for the insured under a valid Power of Attorney. Please submit a copy of the Power of Attorney with this beneficiary form.

Please print and sign below

Insured/Owner first name	Middle name	Last name

Sign Here	Insured/Owner signature	**Date form completed** *(mm/dd/yyyy)*

STOP

Did you remember to...

- ✓ Provide complete information for each of your beneficiaries?
- ✓ Make sure the total "proceeds %" for your **primary beneficiaries** *(including those on a separate page)* equals 100%? Separately, did you remember to make sure the total "proceeds %" for your **contingent beneficiaries** *(including those on a separate page)* equals 100%?
- ✓ Complete, sign and date any extra pages that list beneficiary information *(such as Living Trust/ Charity/Organization beneficiaries)*?
- ✓ Cross out and initial any mistakes you made? *(If you crossed out any answers, your signature is not enough. You must also initial all your corrections.)*

  Example: ~~12/20/25~~ 12/20/15 *HM* ⇦ *answer corrected, initials required*

Please note: we cannot record your beneficiary choices unless you complete these items.

SECTION 6: How to submit this form

Return this **entire** form *(and any additional pages)* to your employer or benefits administrator. Retain a copy of this completed form for your records.