

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 for status changes.

✓ **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.

✓ **Modifying dependents:** When you add or remove dependents, you must provide documentation demonstrating that the dependents are eligible for benefits.

Additional Benefits documentation demonstrating eligibility is required

You only need to complete the forms that pertain to you.
You may 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
- 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 boxes to indicate a change to my personal information as indicated below:

Physical Address: _____

If different, provide Mailing: _____

Telephone Number: _____

Home Cell

Marital Status: Please provide supporting documents with this form.

Single

Married

Widowed

Divorced

Add Remove the following spouse/dependent(s):

Name	Relationship	Gender	Date of Birth	Social Security #
	<input type="checkbox"/> Dependent	<input type="checkbox"/> Male <input type="checkbox"/> Female		

Check emergency contact person: (if applicable)

(Name)

(Address)

(City, State, Zip)

(Phone Number)

(Signature)

(Date)

Highmark

Received in HR



RESIDENCY CERTIFICATION FORM

Local Earned Income Tax Withholding

TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers and taxpayers to report information for the collection and distribution of local earned income taxes. This form must be completed by employers and taxpayers. For more information, visit the Pennsylvania Department of Community & Economic Development website at www.newPA.com/Act32 or call 1-800-786-2277.

STREET ADDRESS (No PO Box, RD or RR)			
ADDRESS LINE 2			
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
MUNICIPALITY (City, Borough or Township)			
RESIDENT ORN CODE			TOTAL RESIDENT EIT RATE

EMPLOYER BUSINESS NAME (Use 1 location only)			2 4 0 7 9 5 4 9 5			
University of Scranton						
STREET ADDRESS WHERE ABOVE EMPLOYEE REPORTS TO WORK (No PO Box, RD or RR)						
ADDRESS LINE 2						
CITY	STATE	ZIP CODE	PHONE NUMBER			
Scranton	PA	18510	717-344-7337			
MUNICIPALITY (City, Borough or Township)						
Scranton						
COUNTY	MUNICIPALITY ORN CODE					
Lackawanna	0 1 5 0 0 0 1					

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

SIGNATURE OF EMPLOYEE	DATE (MM/DD/YYYY)
DUPLICATE ADDRESS	EMAIL ADDRESS

For information on obtaining the appropriate information for employers, taxpayers, please refer to the Pennsylvania Department of Community & Economic Development website:

www.newPA.com/Act32

Form **W-4**

► 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

Department of the Treasury
Internal Revenue Service

Step 1: (a) First name and middle initial Last name (b) Social security number

Personal Information

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)

claim exemption from withholding, when to use the estimator at www.irs.gov/W4App, and privacy.

Multiple Jobs or Spouse

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

withholding; or

income, including as an independent contractor, use the estimator

Complete Steps 3-4 (b) on the Form W-4 for the highest paying job.)
be most accurate if you complete Steps 3-4(b) on the Form W-4 for the highest paying job.)

Claim Dependents

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

Step 4 (a) Other income (not from job). If you want tax withheld for other income you

This may include interest, dividends, and retirement/annuity/pension and investment income.

Other Adjustments

(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

Only

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

change the amount of federal income tax withheld from your

withholding each week, you should complete Form W-4.

See Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption

from withholding only if you meet one 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)

you were not required to file a return because your

gross income for the year was less than the sum of lines 27a, 28, 29, and 30, or

if you were not required to file a return because you

are a nonresident alien. If you claim exemption, you will have no income tax

withheld from your pay. To claim

exemption, you must certify that you meet both of

the conditions above on Form W-4.

Our privacy notice is available at www.irs.gov/privacy.

Steps 2 through 4, use the online calculator in the

Instructions to determine the amount to enter on line 5.

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

more than one job, you may enter an additional amount

you want withheld per pay period in Step 4(b), and if you

only have one job in your household, you may instead check the box

significantly reduce your paycheck (see the instructions for

line 5).

2. Have dividend or capital gain income, or are subject to

additional taxes, such as Additional Medicare Tax;

3. Have self-employment income (see the instructions for

line 5).

4. Have other income, such as rental income, that is not

subject to withholding (see the instructions for line 5).

5. Have other income, such as rental income, that is not

subject to withholding (see the instructions for line 5).

6. Have other income, such as rental income, that is not

subject to withholding (see the instructions for line 5).

7. Have other income, such as rental income, that is not

subject to withholding (see the instructions for line 5).

Specific Instructions

Step 1(a). Check your withholding 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 time you are receiving your pay and you are your own employer for one or more of the jobs, or (2) you are an employee on both work

and you are an employer for one or more of the jobs. The calculator calculates the additional tax you need to have withheld, while option (b) does so with a flat rate.

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

based on the combined income of both jobs.

Multiple jobs. Complete Steps 3 through 4(b) on only

one Form W-4 for the highest paying job.

CAUTION You do this on the Form W-4 for the highest paying job.

Child tax credit. See the 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

return. For the child tax credit, the child must

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

qualifying child, and must have the required social security number.

You may be able to claim a credit for other dependents for

other dependents, such as an older

relative, if you are the taxpayer or the taxpayer's spouse.

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other dependents, such as an older

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relative, if you are the taxpayer or the taxpayer's spouse.

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(a) 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 ONE Form W-4 for the highest paying job.

4. Two jobs. If you have two jobs reported (filling 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.

2c below. Otherwise, skip to line 3.

2a. 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 \$

2b. 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 \$

2c. 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.

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: charitable contributions; mortgage interest; state and local taxes (up to \$10,000); and other itemized deductions.

2. Enter: \$25,000 if you're married filing jointly or a qualifying widow(er); \$19,000 if you're head of household; \$12,000 if you're single or married filing separately.

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 \$

Married Filing Jointly or Qualifying Wldow(er)

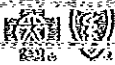
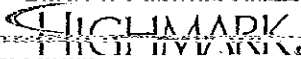
Higher Paying Job Annual Taxable	Lower Paying Job Annual Taxable Wage & Salary											
	\$0	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000	\$110,000
\$20,000 - 29,999	850	1,860	2,800	3,000	3,160	3,160	3,160	3,160	3,160	3,910	4,910	5,910
\$30,000 - 39,999	1,020	2,220	3,100	3,300	3,460	3,460	3,460	3,460	3,460	4,210	5,210	6,210
\$40,000 - 49,999	1,020	2,220	3,100	3,300	3,460	3,460	3,460	3,460	3,460	4,210	5,210	6,210
\$50,000 - 59,999	1,020	2,220	3,100	3,300	3,460	3,460	3,460	3,460	3,460	4,210	5,210	6,210
\$60,000 - 69,999	1,020	2,220	3,100	3,300	3,460	3,460	3,460	3,460	3,460	4,210	5,210	6,210
\$70,000 - 79,999	1,020	2,220	3,100	3,300	3,460	3,460	3,460	3,460	3,460	4,210	5,210	6,210
\$80,000 - 89,999	1,020	2,220	3,100	3,300	3,460	3,460	3,460	3,460	3,460	4,210	5,210	6,210
\$90,000 - 99,999	1,020	2,220	3,100	3,300	3,460	3,460	3,460	3,460	3,460	4,210	5,210	6,210
\$100,000 and over	1,400	4,440	6,680	7,980	9,340	10,540	11,740	12,940	14,140	16,100	18,100	19,190

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	6,360	6,360
\$40,000 - 49,999	1,020	1,890	2,990	3,990	4,990	5,610	5,710	5,910	6,110	6,310	6,360	6,360
\$50,000 - 59,999	1,020	1,890	2,990	3,990	4,990	5,610	5,710	5,910	6,110	6,310	6,360	6,360
\$60,000 - 69,999	1,020	1,890	2,990	3,990	4,990	5,610	5,710	5,910	6,110	6,310	6,360	6,360
\$70,000 - 79,999	1,020	1,890	2,990	3,990	4,990	5,610	5,710	5,910	6,110	6,310	6,360	6,360
\$80,000 - 89,999	1,020	1,890	2,990	3,990	4,990	5,610	5,710	5,910	6,110	6,310	6,360	6,360
\$90,000 - 99,999	1,020	1,890	2,990	3,990	4,990	5,610	5,710	5,910	6,110	6,310	6,360	6,360
\$100,000 - 149,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
\$150,000 - 199,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
\$200,000 and over	2,140	4,900	6,880	11,980	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											
	\$0	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000	\$110,000
\$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



ENROLLMENT WAIVER FORM
ENROLLMENT WAIVER FORM
 COMPLETE THIS APPLICATION IN ITS ENTIRETY

ENROLLING

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

IN BLUE OR BLACK INK.

(Complete sections I and III)

Effective Date: _____ Employee Group Name: _____

First Name: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____ Home/Cell Phone: _____

Single/Unmarried Married Active Employee COBRA Continuation COBRA Life Event

Full-Time Hire (or rehire) Date (month/day/year): _____

Gender: _____ Date of birth (month/day/year): _____

Male Female Child of Board/COOP Group Director PDR 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 (if not using alternative): _____ Male Female

Product Selection(s): Medical Vision Dental PDR Number from Provider Directory Is Spouse/OP an Established Patient?
 YES NO

Male Female

Product Selection(s): Medical Vision Dental

YES NO

Social Security Number (Print)

Male Female

____/____/____
Date of Birth (Print if Age 26 or Older)

Medical Vision Dental

Disabled Act 4

Yes No

Is Child an Established Patient?

First Name

MI Last Name

Relationship to You? Child

Dependent Status if Age 26 or Older

Yes No

If enrolling an adopted child or child that has been placed with you by the state, please attach the state's legal papers to support dependent 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:

- REASON FOR DECLINING MEDICAL COVERAGE:**
- Insured under spouse. Please provide spouse's employer and insurance carrier names:
 - Other:

VISION

DENTAL

I HEREBY DECLINE VISION COVERAGE:

I HEREBY DECLINE DENTAL COVERAGE:

- For family members ONLY
- For the following family members:

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

I hereby acknowledge that I have read the above information and that I have declined the coverage offered by my employer and that I have declined the coverage offered below before coverage will be offered.

Name of Insurance Carrier	Group Number	Effective Date	Name of Policyholder
Policyholder Last, First, Middle Initial	Policy Number	Start Date	End Date
			<input type="checkbox"/> Active <input type="checkbox"/> 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 Date	Medicare Part A	Medicare Part B	Medicare Part C	Medicare Part D	Supplement	
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No

I authorize any payroll deductions required for the coverage and recognize that I may ultimately become my dependent on this form or any other form I file.

To the best of my knowledge and belief, the information furnished on this form is true and correct.

Any person who knowingly and with intent to defraud an insurance company or another 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 his/her family to penalties.

I acknowledge and agree that any personally identifiable health information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is protected by the meaning and use of the term "Protected Health Information" as defined in the HIPAA Privacy Rule. I understand 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 enrollment applications, enrollment/alter forms and all supporting documentation to one of the following addresses:

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

Fax (800) 290-3301

www.enrollmenrandomg@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 DiscoverHighmark.com/CustomAssurance or for a paper copy, call 1-855-873-4105.

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefits determinations.

3831

Dependent Identification Number (Social Security Number)	Date of Birth (mm/dd/yyyy)	Sex	Provider Number (DHMO only)
#3 <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>
First Name	M.I.	Last Name	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

Dependent Identification Number (Social Security Number)	Date of Birth (mm/dd/yyyy)	Sex	Provider Number (DHMO only)
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>
First Name	M.I.	Last Name	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

Dependent Identification Number (Social Security Number)	Date of Birth (mm/dd/yyyy)	Sex	Provider Number (DHMO only)
#5 <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>
First Name	M.I.	Last Name	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

Dependent Identification Number (Social Security Number)	Date of Birth (mm/dd/yyyy)	Sex	Provider Number (DHMO only)
#6 <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>
First Name	M.I.	Last Name	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

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

Insurance Company	Effective Date
<input type="text"/>	<input type="text"/>
Policy/Commission Number	
<input type="text"/>	<input type="text"/>

I represent that all information supplied in this application is true and correct, provided by me or the company or other person, and an application for insurance is being submitted to the insurance company.

Employee Signature	Phone Number	Email Address	Date
<input type="text"/>	570-941-7767	<input type="text"/>	<input type="text"/>
Employer Signature	Phone Number	Date	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

Products Available

Products are not available in any state that 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 of an application containing any other information.

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

of an application containing any other information.

NY: Any person who knowingly and with intent to defraud any insurance act which may be a crime.

benefits unless contained in writing and signed by the Policyholder.

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

KS: Any person who knowingly and with intent to defraud insurance act which may be a crime.

LA: Any person who knowingly and with intent to defraud insurance act which may be a crime.

subject to arbitration as an alternative to court action pursuant

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

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, territories and possessions:

- United Concordia Dental Plans, Inc.—DC, MD, NJ
- United Concordia Dental Plans of California, Inc.—CA

- United Concordia Insurance Company—CT, FL, GA, HI, IA, ID, IN, KS, LA, MA, MD, ME, MI, MN, MS, MT, NE, NH, NY, NM, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WA

- United Concordia Life and Health Insurance Company—DE, DC, IL, KY, MD, MO, NY, NJ, PA
- United Concordia Dental Plans of the Midwest, Inc.—MI, MN, WI

- United Concordia Insurance Company of New York—NY

MEDICAL/DENTAL ENROLLMENT OPTION FORM

I. Premium Conversion Plan

125 participant:

I wish to participate in the Premium Conversion Plan and make contributions toward the cost of medical and dental insurance with _____ 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:

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 company provides for employees and spouses and/or dependents and hereby certify that medical insurance is not being disbursed. I understand that except for a life event as defined by the TDC, I will only be allowed to opt back into coverage during the annual open enrollment period.

Name: _____

Date: _____

Signature: _____



Instructions

To designate beneficiaries or to change your existing beneficiary designation on an annuity plan, complete all applicable sections of this form, obtain the designated beneficiary's consent, and submit this form to your 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/Contract Name: []
Contract/Account No. [] Affiliate No. [] Division No. []

Section B. Personal Information

Social Security No. [] Date of Birth []

Mailing Address []
City [] State [] Zip Code []
Phone No. [] Ext. []
E-mail Address []
Marital Status: Married Single/Divorced

Section C. Primary Beneficiary Designation

This designation will apply to the account number above. You must designate a specific percentage for each beneficiary. Shares must be whole. If you designate more than one beneficiary, the percentages must equal 100%. 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.

Beneficiary Name: [] Relationship: []
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)

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

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

Share of Benefits: % (whole percentages only)

Relationship

Mailing Address

City

State

Zip Code

Share of Benefits: % (whole percentages only)

Relationship

Mailing Address

City

State

Zip Code

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

I understand that I am waiving my qualified pre-retirement survivor 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)

I understand that I am waiving my qualified pre-retirement survivor death benefit coverage. I understand

X _____ X _____
Spouse Signature Date

WITNESSED

X _____ X _____
Plan Administrator or Notary Public Signature and Stamp/Seal Date

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

X _____ X _____
Plan Administrator Signature Date

Supplemental Beneficiary Designations

Social Security No.

First Name/Middle Initial

Last Name

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

Last Name

Date of Birth (mm/dd/yyyy)

First Name/Middle Initial

Social Security No.

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

Home Address

City

State

Zip Code



BENEFICIARY DESIGNATION FORM

Use this form to update existing or new beneficiary designations for your TIAA-CREF account.

Use this form to update existing or new beneficiary designations for your TIAA-CREF account.

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?

you review and update your beneficiary information.

To obtain a form, visit our website
complete and sign it.

Selecting a Beneficiary

A beneficiary can be an individual, an institution, an organization, a testamentary trust, or your estate.

Please consult with an attorney prior to naming a beneficiary. (Naming an estate may have options favorable to you.)

Your primary beneficiary(ies) receives benefits at the time of your death. If there are no living primary beneficiaries of the class unless you specify otherwise. If there are no living primary beneficiaries at the time of your death, the benefits become payable to your contingent beneficiaries. If none of the

Spousal Rights to Annuity Death Benefits

If you are married and have designated someone other than your spouse as more than one primary beneficiary, you must also designate your

Community and marital property states include, but are not limited to:

AZ, CA, ID, LA, NY, 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.



Financial Services

BENEFICIARY DESIGNATION FORM

human resources
administrator for any

PLEASE SEE INFORMATION (CONTINUED)

How to waive a preretirement survivor death benefit?

If you are married and want more than 50% of your benefits for the plan determined amount, if greater, to go to someone other than your spouse, you must first complete a Spousal Waiver before your plan

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

Waiver form. If your spouse cannot complete a Spousal Waiver before your plan

complete another Spousal Waiver once you attain age 55.

If you are married and want more than 50% of your benefits for the plan determined amount, if greater, to go to

someone other than your spouse, you must first complete a Spousal Waiver before your plan

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

Waiver form. If your spouse cannot complete a Spousal Waiver before your plan

10/15/00



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)

Select one of the following 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)

If you change address, change update SSN, etc.



Financial Services

Check the first box if you
check one and you are
not the asset beneficiary
designation(s) for all your
applicable TIAA-CREF
annuity contracts. Check

3. APPLICABLE CONTRACTS

This beneficiary designation applies to:

ALL TIAA-CREF annuity and IRA contracts
I have listed below.

you want the beneficiary

ONLY TIAA-CREF annuity or IRA contract set(s) indicated below.

specific contracts.

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

TIAA Number

Grid for TIAA Number

CREF NUMBER

Grid for CREF NUMBER

TIAA Number

Grid for TIAA Number

CREF Number

Grid for CREF Number

TIAA Number

Grid for TIAA Number

CREF Number

Grid for CREF Number

call us at 800 842-2252.





LEGITIMARY DESIGNATION FORM

A beneficiary can be an individual, an institution,

4. CHOOSING YOUR PRIMARY BENEFICIARY

a testamentary trust,* or

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

beneficiary receives

benefits if I am defined under federal law at the time of my death, or will

beneficiaries. If none of the beneficiaries are dead at the time of your death, the benefits go

OR

Middle Initial

acceptable if we are provided the data

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 amount which would have been paid to that beneficiary will be

among his/her children

Address

City State Zip Code

Contact Telephone Number Country Gender F M

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

2. PRIMARY BENEFICIARY

ately to the remaining beneficiaries in that class

Last Name Percentage

other beneficiaries, we will

Address

See Provisions at end of this form

City State Zip Code

Contact Telephone Number Country Gender F M

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

Per stripes**





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

4. PRIMARY BENEFICIARY
[Empty box for beneficiary name]

'Will' as a designation. Testamentary trusts are

Address: [Empty box]

Use 'Will' under trust Testamentary Trust

Contact Telephone Number Country Gender

If you check, you

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

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

Per stirpes*

4. PRIMARY BENEFICIARY

[Empty box for beneficiary name]

In the event there are no other beneficiaries, we

Address: [Empty box]

City State Zip Code

Contact Telephone Number Country Gender

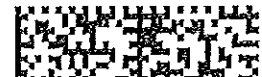
Social Security Number/ Taxpayer Identification Number Date of Birth/Date of Trust/ Issue Date of Will (mm/dd/yyyy) Relationship

[Empty box for beneficiary name]

Per stirpes*

Check this box and attach a signed letter, to list additional primary and/or contingent beneficiaries,

with copy to provide additional instructions. Please include your contact numbers





If you have more than one contingent beneficiary

...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.

CONTINGENT BENEFICIARIES

1. CONTINGENT BENEFICIARY

First Name

Middle Initial

Last Name

Percentage

Address

City

State

Zip Code

*If you check 'per stirpes' and the named beneficiary is deceased

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

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 proportionately to the remaining

Per stirpes*

First Name

Middle Initial

In the event there are no other beneficiaries, we

Address

City

State

Zip Code

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

Social Security Number / Taxpayer Identification Number

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

Relationship

Per stirpes*

CONTINUED ON NEXT PAGE





Financial Services

BENEFICIARY DESIGNATION FORM

Page 6 of 8

one contingent beneficiary; benefits will be divided equally among the living

3. CONTINGENT BENEFICIARY

First Name

Middle Initial

The amount for

total 100%.

Address

will as a designator. Testamentary trusts are acceptable if you are

City

State

Zip Code

*If you check 'per

Social Security Number /

Taxpayer Identification Number

Date of Birth / Date of Trust /

Issue Date of Will (mm/dd/yyyy)

Relationship

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-

Per stirpes*

4. CONTINGENT BENEFICIARY

First Name

Middle Initial

Last Name

Relationship

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

Address

City

State

Zip Code

Contact Telephone Number

Country

Gender

Social Security Number /

Date of Birth / Date of Will

Per stirpes*





Financial Services

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.

If I am all of my 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 my benefits will be paid as outlined in this form.
- I understand and agree to the changes and updates I made on this form.





BENEFICIARY DESIGNATION FORM

The Employee Retirement Income Security Act of 1974 (ERISA) provides...

100% to a surviving spouse at death.

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

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

ADDITIONAL REQUIREMENTS BASED ON MARITAL STATUS

IF YOU ARE SINGLE, WIDOWED, OR DIVORCED

Check the box if you are not married

I am not married.

IF YOU ARE MARRIED

...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

...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, the undersigned, do hereby consent to my spouse being named as a beneficiary of the death benefit that I may be entitled to

under the plan and I acknowledge that I understand the consequences of my actions.

First Name (Please print)

Last Name (Please print)

Your Signature

Today's Date (mm/dd/yyyy)

MARITAL STATUS CERTIFICATION

... 7/20/...

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

Notary Public's Signature

Today's Date (mm/dd/yyyy)

Testimony of a credible witness.

Provide the notarial seal outside New York state.

MASSACHUSETTS ONLY

PLAN REPRESENTATIVE CERTIFICATION

Plan Representative Name (Please print) Title





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 Section 7A; if you are married and have not designated your spouse as a primary beneficiary of at least

front of a Notary Public or your current employer's plan representative.

Original documents are required. Faxes cannot

PLEASE RETURN COMPLETED FORM TO:

TIAA-CREF

TIAA-CREF

9500 Andrew Corporate Blvd





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

Unless otherwise indicated, you elect that, upon your death 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 (as last specified upon your death under a Two-Life Annuity) will be paid in accordance with the proportions stated. If a beneficiary predeceases you (or the last surviving annuitant under a Two-Life annuity under a Two-Life Annuity), all benefits





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, 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

John Doe's share 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 share of any qualified beneficiaries. If there are no other beneficiaries, we will pay your Estate.

4. If a Testamentary Trust is Designated as Beneficiary:

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

TIAA-CREF will accept a testamentary trust if you have no other beneficiaries in the will or trust instrument designation. A designation of Will is not acceptable.

- 6. 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 surviving annuitant in a Two-Life Annuity; or (iii) if evidence is furnished and is satisfactory to TIAA-CREF

surviving annuitant).

If benefits become payable to an inter vivos trust and (i) the trust agreement is not in effect or (ii)

otherwise to your estate (or to the estate of the last surviving annuitant).

Payment to and receipt by said trustee, said successor beneficiary/ies or said estate, as provided

for in (a) and (b) above, shall fully discharge TIAA-CREF from liability for the event of such payment

TIAA-CREF shall have no obligations as to the application of funds so paid and shall, in all dealings

release, as holder of interest, be fully protected against the claims or demands of any other person(s)





FRAUD WARNING

This notice/warning does not apply in New York.

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

