Print Form

CashPlus
Sharing the Commitment.

St. Peter's Hospital

ENROLLMENT & BENEFICIARY DESIGNATION FORM
St. Peter's Hospital CashPlus Plan

Member's Name: _____ Social Security #: _____

Address: _____ Date of Birth: _____

_____ Date of Hire: _____

Spouse's Name: _____ Date of Birth: _____

I hereby designate the following person as the primary Beneficiary of benefits payable under the St. Peter's Hospital CashPlus Plan in the event of my death:

Name: _____

Address: _____

Social Security #: _____ Relationship: _____

In the event the primary Beneficiary's death precedes mine, benefits should be payable to:

Name: _____

Address: _____

Social Security #: _____ Relationship: _____

_____ _____
Member's Signature Date

If you are married and name someone ***other than your spouse*** as primary Beneficiary of the death benefits payable under the Plan, your spouse ***must*** sign the following in the presence of a plan representative or Notary Public.

I approve and consent to the beneficiary designation above, and I understand that I am relinquishing all interest I may have in death benefits under the St. Peter's Hospital CashPlus Plan, except to the extent I am designated as a beneficiary above. I understand that my consent is irrevocable, but that if my spouse changes his/her election or names a beneficiary other than as named above, my consent must again be obtained.

Spouse's Signature: _____ Date: _____

_____ has subscribed and sworn before me this _____ day of _____, 19 _____
that he/she is one and the same person whose name is signed above.

Notary Public
For the State of _____ and County of _____
_____ _____
Residing at
Commission expires _____
_____

OR

Plan Representative _____

Date _____

For more information about death benefits and other rights under the Plan, please consult your summary Plan Description or contact the Human Resources Department.