

*Securing Your Tomorrow*

## DESIGNATION OF BENEFICIARY FOR UNUSED CONTRIBUTIONS AND ACCRUED PAYMENTS – ALL MEMBERS

**PLEASE NOTE: Any benefit overpayment that LACERS cannot collect will be deducted from benefits payable to your beneficiary(ies).**

I, \_\_\_\_\_, Social Security Number \_\_\_\_\_,  
(Print Your Name)

in the event of my death, hereby designate the following primary beneficiary(ies) to receive the portion of my retirement contributions, if any, that remains *unused* upon the date of my death, and any *accrued* monthly retirement allowance (my prorated allowance for the month of my death) that is due but that remains unpaid upon the date of my death, except that, if my spouse/domestic partner survives me, my accrued allowance is to be paid to him/her. (Unless you indicate otherwise when you designate your primary beneficiaries, your unused contributions and accrued payments will be paid in equal shares to any primary beneficiaries who survive you.)

\_\_\_\_\_  
Name Date of Birth

\_\_\_\_\_  
Relationship Social Security Number (Optional) Telephone Number

\_\_\_\_\_  
Street Address City State Zip

\_\_\_\_\_  
Name Date of Birth

\_\_\_\_\_  
Relationship Social Security Number (Optional) Telephone Number

\_\_\_\_\_  
Street Address City State Zip

\_\_\_\_\_  
Name Date of Birth

\_\_\_\_\_  
Relationship Social Security Number (Optional) Telephone Number

\_\_\_\_\_  
Street Address City State Zip

**I understand that, if I retired on a life annuity, no contributions will be refunded upon my death.**

\_\_\_\_\_  
Member's Signature Date

**SPOUSAL CONSENT TO THIS DESIGNATION** (Domestic Partners do not need to sign this designation)  
I, \_\_\_\_\_ hereby join in the above designation and request that  
(Print Name of Spouse)  
payment be made in accordance therewith. \_\_\_\_\_  
Spouse's Signature

(Unless you indicate otherwise when you designate your primary beneficiary, your unused contributions and accrued payments will be paid in equal shares to any primary beneficiaries who survive you.)

**If the primary beneficiary(ies) named on the first page of this form is/are deceased, I then designate the following secondary beneficiary(ies):**

Name		Date of Birth	
Relationship	Social Security Number (Optional)	Telephone Number	
Street Address (No P.O. Boxes)	City	State	Zip Code

Name		Date of Birth	
Relationship	Social Security Number (Optional)	Telephone Number	
Street Address (No P.O. Boxes)	City	State	Zip Code

Name		Date of Birth	
Relationship	Social Security Number (Optional)	Telephone Number	
Street Address (No P.O. Boxes)	City	State	Zip Code

Name		Date of Birth	
Relationship	Social Security Number (Optional)	Telephone Number	
Street Address (No P.O. Boxes)	City	State	Zip Code

Member's Signature	Date
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### **ADA NOTICE**

As a covered entity under Title II of the Americans with Disabilities Act, the City of Los Angeles does not discriminate on the basis of disability and, upon request, will provide reasonable accommodations to ensure equal access to its programs, services and activities.