



DESIGNATION OF BENEFICIARY

Unpaid Compensation of Deceased Civilian Employee

A. Identification

Name (Last, First, Middle)

Date of birth: (mm/dd/yyyy)

Social Security Number:

Department or agency in which presently employed:

Department& N-Code:

Location (City, State, and Zip Code):

I, the employee named above, canceling any and all previous Designations of Beneficiary made by me, do now designate the following beneficiary(ies) named below to receive any unpaid compensation due and payable after my death. I understand that this Designation of Beneficiary relates solely to money due as defined in 5 U.S.C.5581, 5582, 5583, and in no way will affect the disposition of any benefit which may become payable under my Retirement or Group Life Insurance Acts applicable to my Government service. I further understand that this Designation of Beneficiary will remain in full force and effect until I change it in writing.

B. Beneficiary Information (*if you have more beneficiaries you may write them on the back or attach an additional sheet of paper)

Name of Primary Beneficiary(ies): (First, Middle, Last)	Beneficiary Date of Birth: (mm/dd/yyyy)	Address: (Street, City, State, and Zip)	Phone #:	Relationship to employee:	Beneficiary Percentage: (%)
Name of Contingent Beneficiary(ies): (First, Middle, Last)	Beneficiary Date of Birth: (mm/dd/yyyy)	Address: (Street, City, State, and Zip)	Phone#:	Relationship to employee:	Beneficiary Percentage: (%)
Date of designation (mm/dd/yyyy):	Employee Signature:				Total %=

C. Witnesses (two required) (A witness is not eligible to receive payment as a beneficiary):

We, the undersigned, certify that this statement was signed in our presence.

Printed Name of Witness:	Witness Signature:	Address (Street, City, State, Zip):	Date:

Human Resources (CNIC) certification:

I have reviewed this designation and certify that the designated shares total 100%, and that no witnesses are designated as beneficiaries.

Printed Name:	Signature:	Date: