

**DIOCESE OF ALLENTOWN  
LAY EMPLOYEE PENSION PLAN  
BENEFICIARY/CHANGE FORM**

Name: .....

Street: .....

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Social Security: \_\_\_\_\_ Email: \_\_\_\_\_

**New Address? Yes No** *If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%*

**I hereby designate my beneficiaries to be (use full name) if living.**

**Primary:**

Name	Relationship	Percentage
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Social Security	Home Phone	Cell Phone
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Address	City	State	Zip Code	Email
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Name	Relationship	Percentage
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Social Security	Home Phone	Cell Phone
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Address	City	State	Zip Code	Email
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**Secondary:**

Name	Relationship	Percentage
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Social Security	Home Phone	Cell Phone
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Address	City	State	Zip Code	Email
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With the proceeds on death payable as a lump sum, reserving the right to change the beneficiary. The change will go into effect when this form is received at the Human Resources Office.

The right to change this designation is reserved to the insured under the terms of the policy.

\_\_\_\_\_  
Signature of Insured \_\_\_\_\_  
Date