

PERSONAL INFORMATION (please print clearly using black or blue ink)

NAME: _____ SOCIAL SECURITY NUMBER: _____
 ADDRESS: _____ APT: _____
 CITY: _____ STATE: _____ ZIP CODE: _____
 DAY PHONE: _____ EVENING PHONE: _____
 EMAIL: _____ DATE OF BIRTH: ____/____/____
 MARITAL STATUS: _____ SCHOOL DISTRICT PLAN NUMBER: _____

I am married. If my spouse is not the sole Primary Beneficiary, my spouse has signed the spousal consent. If my spouse does not sign such consent, I understand that any death benefits under the Plan will automatically be payable in full to my surviving spouse.

I am NOT married. I understand that if I become married in the future, this form automatically ceases to apply and I should file a new beneficiary designation.

INSTRUCTIONS

1. You can make or change your beneficiary designations by speaking with a Customer Service Associate or go online. Please contact a Customer Service Associate at 844-electP2 (844-353-2872) (TTY/TTD users call 800-468-5449) or go online at Pension2.com.
2. You may access the online tool under Personal Information to elect your beneficiary(ies).
3. If you designate a trust as a beneficiary, please include the trust name and trust date.
4. If you are married, please note that your sole Primary Beneficiary must be your spouse unless you complete Spousal Consent section of this form.
5. If you list more than one beneficiary, the total of all Primary and/or Contingent Beneficiaries must be in whole increments and equal 100%. If you need to add additional names, please use the back of this form clearly labeling Primary or Contingent Beneficiaries.
6. If your Primary Beneficiary(ies) die(s) before you, then Plan benefits will be distributed to Contingent Beneficiary(ies).
7. If a primary beneficiary dies prior to distribution, the remaining account will be divided equally amongst the surviving primary beneficiaries.
8. Good order is receipt of the designated location of this form accurately and entirely completed, and includes all necessary signatures. If this form is not received in good order, as we determine, it may be returned to you for correction and process upon re-submission at our designated location.
9. If you are enrolled in both the 403(b) and 457 plans and want to elect different beneficiaries for both plans, you will need to complete a separate form.

PRIMARY BENEFICIARY(IES)

Full Name and Address	Social Security Number	Date of Birth	Relationship to You	Percent of Benefit* (Whole % only, must total 100%)
1 _____ _____ _____	_____	____/____/____ M M D D Y Y Y Y		___ __ .00%
2 _____ _____ _____	_____	____/____/____ M M D D Y Y Y Y		___ __ .00%
3 _____ _____ _____	_____	____/____/____ M M D D Y Y Y Y		___ __ .00%
4 _____ _____ _____	_____	____/____/____ M M D D Y Y Y Y		___ __ .00%

*If you list more than one beneficiary, the total of all Primary Beneficiaries must be in whole increments and equal 100%. If your elections do not equal 100%, your form will be rejected.

100%

SPOUSAL CONSENT (If spouse is not the sole Primary Beneficiary)

Your spouse must consent and acknowledge by signing below if he/she is not the sole Primary Beneficiary.

I hereby consent to the foregoing election by my spouse, to have his/her benefits paid to a person other than me. I understand **(1)** that the effect of such designation is to cause my spouse's death benefit to be paid to a beneficiary other than me; **(2)** that each beneficiary designated is not valid unless I consent to it; and **(3)** that my consent is irrevocable unless my spouse revokes the beneficiary designation.

I hereby acknowledge that I have had the opportunity to consult with an attorney or other professional concerning this waiver, if I had so desired.

Executed this _____ day of _____ 20 _____

 Spouse's Signature Print Name

WITNESSED BY (only ONE required):

 Plan Representative Signature Print Name

 Notary Signature Print Name

CONTINGENT BENEFICIARY(IES)

Full Name and Address	Social Security Number	Date of Birth	Relationship to You	Percent of Benefit* (Whole % only, must total 100%)
1 _____ _____ _____	_____	____/____/____ M M D D Y Y Y Y		___ __ .00%
2 _____ _____ _____	_____	____/____/____ M M D D Y Y Y Y		___ __ .00%
3 _____ _____ _____	_____	____/____/____ M M D D Y Y Y Y		___ __ .00%
4 _____ _____ _____	_____	____/____/____ M M D D Y Y Y Y		___ __ .00%
*If you list more than one beneficiary, the total of all Contingent Beneficiaries must be in whole increments and equal 100%. If your elections do not equal 100%, your form will be rejected.				100%

AUTHORIZATION

Subject to the spousal consent requirements, I understand that I may revoke or change this designation at any time by filing a new designation of beneficiary in writing with the CalSTRS Pension2 and that by doing so, I revoke all prior designations.

I understand that if none of the above-named beneficiary(ies) survive me, all benefits under the Plan will be distributed according to the provisions established by California law.

I hereby certify under the pains and penalties of perjury that the information I furnished herein is true, accurate and complete.

PARTICIPANT SIGNATURE _____ **DATE** _____

CHECKLIST

PLEASE REVIEW YOUR APPLICATION CAREFULLY.

- Read the required instructions.
- Provided complete personal information including name, Social Security number, and marital status.
- Provided your Primary Beneficiary(ies). Make sure you have completed all the sections and that your percentages of benefit total 100%.
- Had the Spousal Consent section signed and notarized (with an official notary stamp or seal) if you are married and do not name your spouse as your sole Primary Beneficiary.
- Completed the Contingent Beneficiaries section (only if you want to have contingent beneficiaries). The total percent equals 100% of benefit.
- Listed the name, address, Social Security number, birth date and relationship of all Beneficiaries.
- Signed and dated your Beneficiary Designation (Authorized Signature). Must be dated in the last 90 days.
- Made a copy for your records and send the original to CalSTRS Pension2 Plan Administration.

If your application is complete, please mail or fax the application and any additional documents to:

VIA FAX

Voya Financial
Attn: CalSTRS Pension2 Plan Administration
1-888-814-5862

VIA MAIL

Voya Financial
Attn: CalSTRS Pension2 Plan Administration
P.O. Box 389
Hartford, CT 06141

VIA OVERNIGHT DELIVERY

Voya Financial
Attn: CalSTRS Pension2 Plan Administration
One Orange Way
Windsor, CT 06095

You will receive a confirmation statement on your beneficiary elections. If you have any questions or need to obtain additional plan or account information, please go online at Pension2.com or call the CalSTRS Pension2 Service Center at 1-844-elect2 (1-844-353-2872) (TTY/TTD users call 1-800-468-5449). Customer Service Associates are available Monday through Friday, 6:00 A.M. to 5:00 P.M. Pacific Time (excluding stock market holidays).