

# Designation of Beneficiary

Unpaid Compensation  
of Deceased Employee

Board of Governors  
of the Federal Reserve System

Name of Employee (Last, First, Middle)	Mail Stop	Social Security Number
--	-----------	------------------------

I hereby designate the beneficiary or beneficiaries named below to receive any UNPAID COMPENSATION payable to me after my death and, in doing so, cancel any and all previous beneficiary designations I may have made for this purpose. I understand that this Designation of Beneficiary relates solely to UNPAID COMPENSATION (which means pay on account of services rendered prior to death, and not received by me prior to death, and may include amounts due in reimbursement of travel expenses, moving relocation expenses, overtime pay, cash awards, accrued annual leave and/or any other amounts the Board agreed in writing to pay you prior to death). This Designation of Beneficiary does not affect the disposition of any benefits which may become payable under the terms of any other employee benefit plan.

I UNDERSTAND THAT IF I DO NOT DESIGNATE A BENEFICIARY ON THIS FORM, MY UNPAID COMPENSATION WILL BE PAID TO THE PROBATE OR ORPHAN'S COURT (OR SIMILAR INSTITUTION) OF THE STATE WHERE I RESIDED AT THE TIME OF MY DEATH FOR APPROPRIATE DISPOSITION IN ACCORDANCE WITH APPLICABLE STATE LAW. (Your residence will be determined by the most recent address you submitted to the Board for tax purposes (W-2 wage reporting) prior to your death.)

### Information Concerning the Beneficiary or Beneficiaries:

Type or print first name middle initial, and last name of each beneficiary	Type or print address of each beneficiary	Social Security Number	Relationship	Share to be paid to each beneficiary
--	---	------------------------	--------------	--------------------------------------

### Primary Beneficiaries

TOTAL (must equal 100%)				

### Contingent Beneficiaries

TOTAL (must equal 100%)				

I hereby direct, unless otherwise indicated above, that, if more than one beneficiary is named, the share of any deceased beneficiary who may predecease me shall be distributed equally among the surviving beneficiaries, or entirely to the survivor. I understand that his Designation of Beneficiary shall be void if none of the designated beneficiaries is living at the time of my death.

I hereby reserve the right to cancel or change any designation of beneficiary at any time without the knowledge or consent of the beneficiary.

\_\_\_\_\_  
Date of Execution (month, day, year)

\_\_\_\_\_  
Signature of Employee

### Received in Management Division:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Benefits Counselor

To be valid, this form must be received by the Management Division prior to your death. Return this form to the Benefits Section of the Management Division, mail stop 146. A copy will be noted and returned to the employee.