



INSTRUCTIONS

To designate a beneficiary or to change your existing beneficiary designation on your plan, complete all applicable sections of this form, obtain any required signatures, and return it to your Plan Sponsor at Fond du Lac Reservation Business Committee 1720 Big Lake Road, Cloquet, MN 55720. Phone: 218-878-7539 Fax: 218-878-7373. If you have any questions regarding this form, please contact us at 800-755-5801.

PLAN SPONSOR INFORMATION

Plan Name	Fond du Lac Employee Retirement Plan		
Contract/Account No.	QK62600	Affiliate No.	00001
		Division No.	

PERSONAL INFORMATION

Social Security No.		Date of Birth (mm/dd/yyyy)	
First Name/Middle Initial		Last Name	
Mailing Address			
City		State	
		Zip Code	
Phone No.		Ext.	
E-mail Address			



PRIMARY BENEFICIARY DESIGNATION - WILL RECEIVE BENEFITS IN THE EVENT OF YOUR DEATH

This designation will apply to the account number above. You must designate a specific percentage for each beneficiary. Shares must be whole percentages and total 100%. If you do not indicate shares, benefits will be split equally among surviving beneficiaries. If the named beneficiary is a trust, please specify the name and date of the trust under Entity Name and also provide the name of the Trustee.

Note: Share of benefits must total 100% for primary beneficiaries. If additional space is needed to designate multiple beneficiaries, complete the Supplemental Beneficiary Designation page.

Type of Beneficiary Designation [] Individual [] Entity

Share of Benefits % (whole percentages only) Relationship

Social Security No. Date of Birth
(mm/dd/yyyy)

First Name/Middle Initial Last Name

Entity Name

Trustee/Executor

Entity Tax ID Effective Date

Mailing Address

City State Zip Code

PRIMARY BENEFICIARY DESIGNATION (CONTINUED)

Type of Beneficiary Designation [] Individual [] Entity

Share of Benefits % (whole percentages only) Relationship

Social Security No. Date of Birth
(mm/dd/yyyy)

First Name/Middle Initial Last Name

Entity Name

Trustee/Executor

Entity Tax ID Effective Date

Mailing Address

City State Zip Code



CONTINGENT BENEFICIARY - WILL RECEIVE BENEFITS IF NO PRIMARY BENEFICIARY IS LIVING AT THE TIME OF YOUR DEATH

Note: Share of benefits must total 100% for contingent beneficiaries. If additional space is needed to designate multiple beneficiaries, complete the Supplemental Beneficiary Designation page.

Type of Beneficiary Designation [] Individual [] Entity

Share of Benefits % (whole percentages only) Relationship

Social Security No. Date of Birth
(mm/dd/yyyy)

First Name/Middle Initial Last Name

Entity Name

Trustee/Executor

Entity Tax ID Effective Date

Mailing Address

City State Zip Code

CONTINGENT BENEFICIARY DESIGNATION (CONTINUED)

Type of Beneficiary Designation [] Individual [] Entity

Share of Benefits % (whole percentages only) Relationship

Social Security No. Date of Birth
(mm/dd/yyyy)

First Name/Middle Initial Last Name

Entity Name

Trustee/Executor

Entity Tax ID Effective Date

Mailing Address

City State Zip Code



SPOUSAL CONSENT (IF SPOUSE IS NOT 100% PRIMARY BENEFICIARY)

I consent to my spouse's designation of the beneficiary. I understand that this means all or a portion of my spouse's death benefit will be paid to the beneficiary(ies) named in this designation other than me. I further understand that this beneficiary designation is not valid without my consent, and that my consent would be needed again if my spouse wishes to change this beneficiary designation.

X _____
Spouse Signature

X _____
Date

WITNESSED

X _____
Notary Public Signature and Stamp/Seal

X _____
Date

PARTICIPANT SIGNATURE

I hereby warrant that all of the statements and information contained in this request/form are true in all respects. I understand that if I have made any false or misleading statements in this request that such statements could result in significant tax consequences and/or other monetary damages to the Plan, my Plan Sponsor and Transamerica. Moreover, I hereby agree to indemnify and hold (a) the Plan, (b) Transamerica, and (c) my Plan Sponsor harmless from any tax consequences and/or other monetary damages that may result in whole or in part from my false and misleading statements I certify that the information provided on this form is correct and complete.

X _____
Participant Signature

X _____
Date

X _____
Print Name

X _____
Social Security Number

PLAN SPONSOR SIGNATURE

I certify that the information provided on this form is correct and complete, and that any required consents and waivers have been obtained.

Reminder: You should confirm your participant's marital status prior to approving this transaction, and obtain spousal consent as needed.

X _____
Plan Sponsor Signature

X _____
Date



Supplemental Beneficiary Designations

Social Security No.	<input type="text"/>		
First Name/Middle Initial	<input type="text"/>	Last Name	<input type="text"/>

Note: Share of benefits must total 100% for primary beneficiaries (will receive benefits in the event of your death) AND 100% for contingent beneficiaries (will receive benefits if no primary beneficiary is living at the time of your death).

	<input type="checkbox"/> Primary Beneficiary		<input type="checkbox"/> Contingent Beneficiary
Type of Beneficiary Designation	<input type="checkbox"/> Individual		<input type="checkbox"/> Entity
Share of Benefits	<input type="text"/>	% (whole percentages only)	Relationship <input type="text"/>
Social Security No.	<input type="text"/>	Date of Birth (mm/dd/yyyy)	<input type="text"/>
First Name/Middle Initial	<input type="text"/>	Last Name	<input type="text"/>
Entity Name	<input type="text"/>		
Trustee/Executor	<input type="text"/>		
Entity Tax ID	<input type="text"/>	Effective Date	<input type="text"/>
Mailing Address	<input type="text"/>		
City	<input type="text"/>	State	<input type="text"/>
		Zip Code	<input type="text"/>

	<input type="checkbox"/> Primary Beneficiary		<input type="checkbox"/> Contingent Beneficiary
Type of Beneficiary Designation	<input type="checkbox"/> Individual		<input type="checkbox"/> Entity
Share of Benefits	<input type="text"/>	% (whole percentages only)	Relationship <input type="text"/>
Social Security No.	<input type="text"/>	Date of Birth (mm/dd/yyyy)	<input type="text"/>
First Name/Middle Initial	<input type="text"/>	Last Name	<input type="text"/>
Entity Name	<input type="text"/>		
Trustee/Executor	<input type="text"/>		
Entity Tax ID	<input type="text"/>	Effective Date	<input type="text"/>
Mailing Address	<input type="text"/>		
City	<input type="text"/>	State	<input type="text"/>
		Zip Code	<input type="text"/>

