State of Alaska Public Employees' Tier IV Defined Contribution Retirement Plan

For My Information

- For questions regarding this form, visit the Web site at www.akdrb.com or contact Service Provider at 1-800-232-0859.
- Use black or blue ink when completing this form.

A  Participant Information

Account extension, if applicable, identifies funds transferred to a beneficiary due to participant's death, alternate payee due to divorce or a participant with multiple accounts.

Account Extension

Social Security Number (Must provide all 9 digits)

Last Name
First Name
M.I.
Date of Birth

Email Address

Daytime Phone Number

Division/Payroll Center

Alternate Phone Number

Married

Unmarried

B  Beneficiary Designation

Primary Beneficiary Designation (Attach an additional sheet to name additional beneficiaries.)

If I am married, my Plan requires my spouse to be named as primary beneficiary for at least 50% of my account balance, or my spouse must consent to my beneficiary designation.

% of Account Balance

Primary Beneficiary Name

Relationship

Social Security Number

Date of Birth

Street Address

City

State

Zip Code

% of Account Balance

Primary Beneficiary Name

Relationship

Social Security Number

Date of Birth

Street Address

City

State

Zip Code

% of Account Balance

Primary Beneficiary Name

Relationship

Social Security Number

Date of Birth

Street Address

City

State

Zip Code

Contingent Beneficiary Designation

% of Account Balance

Contingent Beneficiary Name

Relationship

Social Security Number

Date of Birth

Street Address

City

State

Zip Code

% of Account Balance

Contingent Beneficiary Name

Relationship

Social Security Number

Date of Birth

Street Address

City

State

Zip Code

% of Account Balance

Contingent Beneficiary Name

Relationship

Social Security Number

Date of Birth

Street Address

City

State

Zip Code

% of Account Balance

Contingent Beneficiary Name

Relationship

Social Security Number

Date of Birth

Street Address

City

State

Zip Code
C Signatures and Consent

Participant Consent

I have completed, understand and agree to all pages of this Beneficiary Designation form. Subject to and in accordance with the terms of the Plan, I am making the above beneficiary designations for my vested account in the event of my death. If I have more than one primary beneficiary, the account will be divided as specified. If a primary beneficiary predeceases me, his or her benefit will be allocated to the surviving primary beneficiaries. Contingent beneficiaries will receive a benefit only if there is no surviving primary beneficiary, as specified. If a contingent beneficiary predeceases me, his or her benefit will be allocated to the surviving contingent beneficiaries. If I fail to designate beneficiaries, amounts will be paid pursuant to the terms of the Plan or applicable law. This designation is effective upon execution and delivery to Service Provider. If any information is missing, additional information may be required prior to recording my designation.

This designation supersedes all prior designations. Beneficiaries will share equally if percentages are not provided and any amounts unpaid upon death will be divided equally. Primary and contingent beneficiaries must separately total 100% in whole percentages.

I understand that the Service Provider is required to comply with the regulations and requirements of the Office of Foreign Assets Control, Department of the Treasury ("OFAC"). As a result, the Service Provider cannot conduct business with persons in a blocked country or any person designated by OFAC as a specially designated national or blocked person. For more information, please access the OFAC Web site at: http://www.treasury.gov/about/organizational-structure/offices/Pages/Office-of-Foreign-Assets-Control.aspx.

Important Notice: If I am married and I elect a primary beneficiary other than my spouse or in addition to my spouse, my spouse must consent by signing the Spousal Consent section of this form.

Any person who presents a false or fraudulent claim is subject to criminal and civil penalties.

Participant Signature ______________________________ Date (Required) __________

Spousal Consent

I, (name of spouse) __________________________________, the current spouse of the participant, hereby voluntarily consent to the participant’s primary beneficiary designation above and understand its effect. I understand that by providing such consent, I am waiving my right to receive either all (if I am not designated as a primary beneficiary) or a percentage (if I and another person are designated as primary beneficiaries) of the participant’s vested account which would otherwise be payable to me upon the participant’s death. I understand that my consent is irrevocable unless my spouse changes beneficiary designation or designates me as a primary beneficiary to receive his or her entire vested account balance.

Spouse’s Signature ______________________________ Date (Required) __________

If I live in California and my notary is required to use the state notary form, the following items must be completed by the notary on the state notary form: the title of the form I am completing, the plan name, the plan number, the document date, the participant’s name and participant spouse’s name. The notary forms not containing this information will be rejected and it will delay this request.

My signature must be notarized by a Notary Public or witnessed by my spouse’s Plan Administrator. The date I sign this form must match the date on which my signature is notarized or witnessed.

This form may also be signed in front of a Postmaster or Division of Retirement and Benefits Representative.

Statement of Notary

NOTE: Notary seal must be visible.

The consent to this request was subscribed and sworn (or affirmed) 

State of ____________) to before me on this ______ day of ______, year ______, by SEAL

Judicial ____________) j.s.s. (name of spouse)

District or County of ____________) proved to me on the basis of satisfactory evidence to be the person who appeared before me, who affirmed that such consent represents his/her free and voluntary act.

Notary Public ______________________________ My commission expires / / ______

Authorized Plan Administrator Signature

I accept the information provided by the participant on this form.

If Spousal Consent notarization is not obtained, I certify that the consent was signed by the spouse of the participant in my presence.

Authorized Plan Administrator Signature ______________________________ Date (Required) __________
### Mailing Instructions

<table>
<thead>
<tr>
<th>After all signatures have been obtained, this form can be sent by</th>
<th>OR</th>
<th>OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fax to: 1-303-801-5800</td>
<td>OR</td>
<td>Express Mail to:</td>
</tr>
<tr>
<td>Regular Mail to: Empower Retirement PO Box 173764 Denver, CO 80217-3764</td>
<td></td>
<td>Empower Retirement 8515 E. Orchard Road Greenwood Village, CO 80111</td>
</tr>
</tbody>
</table>

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