STATE OF MONTANA
DEPARTMENT OF ADMINISTRATION

DESIGNATION OF PERSON AUTHORIZED TO RECEIVE DECEDENT'S WARRANTS

INSTRUCTIONS TO EMPLOYEES

1. Complete this form in (typewritten or ink).
2. Show the designee's full name; for example, "Mary Jane Smith", not Mrs. John E. Smith.
3. Show designee's social security number and date of birth.
4. Erasures or corrections may not be made in the designee's name. If an error is made, complete a new set of forms.
5. Sign original in ink. Submit original and a copy to your personnel office or payroll clerk.
6. You may change your designation at any time by filing a new designation with your personnel office or payroll clerk.
7. You may completely revoke a designation at any time but a letter to your employer signed by you (submit a duplicate).
8. Inform your personnel office or payroll clerk when a change occurs in your designee's address.

INSTRUCTIONS TO EMPLOYERS

1. Review the prepared form to make sure the employee has completed it properly.
2. Advise the employee that this form is a legally binding document.
3. Upon the decease of an employee, fill in the information on the bottom of this form; certifying officer should be the agency head or personnel officer.
4. Forward two copies of this form with all unnegotiated warrants to the DOA Accounting office. DO NOT SEND IT TO STATE PAYROLL.
5. If death occurs after the warrant has been issued but it has been negotiated, recover the warrant (if possible) and submit to DOA Accounting with this form.
6. Have your employees periodically review their designation.

EMPLOYEE'S NAME		
	(FIRST) (MIDDLE) (LAST)	SOCIAL SECURITY NUMBER

DESIGNEE

Pursuant to Section 2-18412, MCA, I hereby designate the following person who notwithstanding any other provision of law, shall be entitled upon my death to receive all state warrants, excluding for payment of death benefits and refund of employee retirement contributions, that would have been payable to me as a result of my employment with the State of Montana had I survived.

(FIRST) (MIDDLE) (LAST)	SOCIAL SECURITY NUMBER	DOB

DESIGNEE'S ADDRESS	CITY, STATE, & ZIP CODE

STIPULATION

I hereby revoke any previous designation filed by me.

If the above-named designee cannot be contacted within sixty days after the date of my death, this designation shall be void.

This designation will remain in full force and effect during my employment with the Montana State Agency identified below until revoked in writing by me. This designation will automatically terminate on date final payment is received as result of said employment.

NAME OF STATE AGENCY, BOARD, OR COMMISSION FOR WHICH YOU ARE EMPLOYED	

EMPLOYEE

SIGNATURE	DATE
ADDRESS	
CITY STATE ZIP CODE	
Form P-3 (Revised 12-95)	

AGENCY USE

REVIEWED BY AND DATE	
DESIGNATION	DATE
Revoked	
Auto Canceled	

DATE DECEASED_____ CERTIFYING OFFICER_____