BATTELLE EMPLOYEES' SAVINGS PLAN ("PLAN")
BENEFICIARY DESIGNATION

Participant Information:

Name:_____
Last First M.I.
Employee
ID Number:_____

Marital Status: ☐ Single ☐ Married ☐ Registered Partner *If your marital status changes, you must complete a new form.

Beneficiary Designation:
To the following **PRIMARY BENEFICIARY(IES)** who survive me, in equal shares unless otherwise indicated under "Percent" (Print names in full):

Name (Last, First, MI)	Relationship	Date of Birth	Social Security Number	Percent

To the following **CONTINGENT BENEFICIARY(IES)** (Initial one):

_____ 1. Equally to my children born to or legally adopted by me, if living, otherwise to their issue, per stirpes. (Per Stirpes—the child(ren) of a deceased child share equally in the deceased child's share)
_____ 2. Equally to my children born to or legally adopted by me, who are living at the time of my death
_____ 3. To the person(s) named below, in equal shares unless otherwise indicated under "Percent" (Print names in full):

Name (Last, First, MI)	Relationship	Date of Birth	Social Security Number	Percent*

*Only include a percent if you initialed box 3

I am aware that after my death a designated Primary Beneficiary may designate his/her own Beneficiary(ies) with respect to his/her share of benefits received hereunder. Contingent Beneficiaries shall receive benefits based on this designation only if my Primary Beneficiary(ies) predecease(s) me.

SIGNATURE AND WITNESS

I hereby revoke any prior beneficiary designation made by me and direct benefits which may become payable under the Plan, by reason of my death, shall be paid to the person(s) in the manner indicated below, subject to the terms of the Plan as it may be amended from time to time. I am aware that my spouse or registered partner (or subsequently acquired spouse or registered partner), if living at the time of my death, will be the sole, Primary Beneficiary regardless of whom I designate unless he/she signs the specific consent portion of this form (see reverse side). **This form MUST be signed and witnessed (witness must actually watch as you sign) in order to be considered acceptable. Any form unsigned, without a witness, or with different signature dates of you and your witness will be returned with instructions to fill out a new form. The witness cannot be someone who benefits from the designation.**

Signature		Witness Signature	
Printed Name		Printed Name	
Date		Witness Date	
FOR OFFICE USE ONLY			
Date Received		Plan Representative	

RETURN COMPLETED ORIGINAL DOCUMENT TO YOUR COMPONENT'S BENEFITS ADMINISTRATION DEPARTMENT.

Note: This form will only be accepted by Benefits Administration as a two-sided form. If unable to print double-sided, or copy to make into a one-page, front and back printed form, please contact your component's Benefits Office.

SPOUSAL/REGISTERED PARTNER CONSENT FORM
BATTELLE EMPLOYEES' SAVINGS PLAN ("PLAN")

Completion of the information below is required for the Plan Participant to designate anyone other than his/her spouse or registered partner as sole, Primary Beneficiary.

I, _____ (name of spouse or registered partner), am the spouse/registered partner of _____ (name of Plan Participant). I understand that I have the right to all of my spouse's or registered partner's vested account balance in the Battelle Employees' Savings Plan upon my spouse's or registered partner's death. In accordance with the designation on this form (see reverse side), I agree to give up the right to any or all amounts that I may be entitled to under the terms of the Plan. The effect of this designation is to cause my spouse's or registered partner's vested account balance to be shared with or paid entirely to beneficiary(ies) other than me, unless I agree to the new beneficiary(ies) by signing a new consent. I understand that I do not have to sign this consent and the signing of this consent by me is a voluntary act. **Further, I understand that I may revoke this consent at any time prior to my spouse's or registered partner's death.***

Signature of Spouse
or Registered Partner: _____ Date: _____

Printed Name: _____

As required by law, your signature must be witnessed by an <u>authorized</u> Plan Representative <u>or</u> a Notary Public.

Witnessed by a Plan Representative:

As an authorized Plan Representative, I confirm that the individual who signed the consent above has appeared before me, is known personally by me, or presented satisfactory identification to me, and signed this form in my presence.

Signature of Plan
Representative: _____ Date: _____

Printed Name: _____

-OR-

Witnessed by a Notary Public:

Sworn to and signed before me this _____ day of _____, 20_____.

My commission expires: _____

Signature of
Notary Public: _____

*To revoke this consent, contact your component Benefits Administration Office to initiate the process.

Revised 6/2014