SA 4805-GA (12-2007) Supersedes (3-2004) issue

Instructions for Beneficiary Designation Change Form - SA 4805-GA

Retiree Form for Those Retired *PRIOR to* January 1, 2007

IMPORTANT: Beneficiary changes will NOT go into effect until signed by the employee and a witness (non-family/ non-beneficiary), and with the original returned to the Benefits office (MS-1463).

1. Complete the form with your name, social security number, beneficiary (ies) and check the appropriate Plan(s).

2. The witness must be a Non-Family member who will not be receiving any of the benefit.

3. The Plan called "Retirement Income/Pension Security Plan" applies only to those employees who were employed with Sandia Laboratories prior to 7/1/75 and contributed to the pension plan.

For Retirees Only:	The beneficiary designation on your Basic Group Life Insurance **G-90373** is a "Qualified Family Member" defined as a spouse that you have been married to for one year or more; a dependent child; or a dependent parent. If there is no "Qualified Family Member," then $500 is paid to your estate. **THIS DESIGNATION CANNOT BE CHANGED and a beneficiary form is not needed.**

4. This form applies ONLY to the company paid Basic Supplemental Group Life Insurance. If you have VTL (Voluntary Term Life Insurance), a beneficiary change form (SF 4400-VTL) is available on the web. http://www.sandia.gov/

5. Be sure to make a copy of the beneficiary change forms (and don't forget to file a copy of this form with your other legal documents) before you return the original to the Benefits Department, MS-1463.

6. Children under 18 cannot be paid as a beneficiary until the court appoints a guardian for financial matters or until the child reaches 18. If you still want to include your children, please list individually.

7. Use the word "otherwise" before the name(s) of the contingent beneficiary (ies).

8. A primary beneficiary is the person to whom the death benefits will be paid first. You may wish to name contingent beneficiaries who will share equally if there is no primary beneficiary or if the primary beneficiary is deceased. If the beneficiary or beneficiaries you have selected die before you do or if you have not completed a beneficiary change form, your insurance will be paid to the first eligible recipient(s) in the following order: surviving spouse, children, parents, or estate.

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Sandia National Laboratories

BENEFICIARY DESIGNATION CHANGE FORM

RETIREE FORM FOR THOSE RETIRED *PRIOR TO* JANUARY 1, 2007

BENEFITS DEPARTMENT, MS-1463

NAME _____
(Last Name, First Name, Middle Initial)

Social Security Number _____

NAME CHANGE ONLY
If you have changed your name, list below the name you used previously:

_____
Last Name First Name Middle Initial

When changing beneficiaries, please note the following:

1. Write the beneficiary's name like this – Mary A. Doe – not like this – Mrs. John Doe
2. If you name a beneficiary who is not a member of your family, please indicate the person's social security number and address**.**
3. Remember that if you name several people as primary (or contingent) beneficiaries, they will share equally unless you specifically indicate differently in the percentage column. Please indicate the percentage you wish to go to each beneficiary.

I hereby revoke any previously made designations of Primary and/or contingent beneficiary(ies) and do now designate as my primary and contingent beneficiary(ies), the following named individuals:

Primary Beneficiary(ies)	**Relationship to me**	**%**

Contingent Beneficiary(ies)	**Relationship to me**	**%**

Please indicate below to which plans the beneficiary designations made above apply. If you wish to make a common change to both plans shown below, mark each plan to which the change applies. If you wish to make one change to one plan and a different change to another plan, request additional forms. Forms can be found on the sandia.gov website.

If employed by SNL prior to 7/1/75

☐ Basic Supplemental Group Life Insurance

☐ Contributions from the Retirement Income Plan or Pension Security Plan

Dated at _____ this _____ day of _____, _____
(City, State) (Day) (Month) (Year)

_____
Full Signature of Employee

_____
Full Signature of Witness
(Non-Relative/ Non-Beneficiary)

Return the original to Benefits Department, Mail Stop 1463