PLAN NAME: _____

Beneficiary Designation Form

Please Print. Complete all applicable areas

Part I. Employee Information:

Name: _____ Social Security # _ _ _-_ _ -_ _ _ _

Address: _____ Date of Birth: _ _ /_ _ /_ _ _ _

City: _____ State: ____ ZIP Code: _____

Marital Status: ☐ Married ☐ Single US Citizen/Resident Alien: ☐ Yes ☐ No

Account or Plan Number _____

Instructions: This designation shall be effective upon execution and delivery to the Plan Administrator. All prior designations are no longer valid.

1. You must complete this Form by naming at least one Primary Beneficiary.
2. You may have more than one person or entity as your Primary Beneficiary and/or Contingent Beneficiary. If your designation exceeds the space provided below, you may complete an additional Beneficiary Designation Form. You cannot name the same person or entity as both a Primary and a Contingent Beneficiary.
3. If you are married, and name someone other than your Spouse as your Primary Beneficiary, then you must have your Spouse complete and sign the Spousal Consent section of this Form to approve the person, or entity named herein as your non-spousal Beneficiary.
4. If you are married and fail to file a Beneficiary Designation Form with the Plan Administrator, then your surviving Spouse shall be your Designated Beneficiary.

Part II. Beneficiary Designation: ☐New ☐Change

Complete so that the percentages for each type of Beneficiary equals 100%. If the percentages do not add up to 100% the benefit will be paid in equal shares.

Primary Beneficiary

In the event of my death, I name the following as my Primary Beneficiary:

Name: _____ Social Security # _ _ _-_ _ -_ _ _ _

Address: _____ Date of Birth: _ _ /_ _ /_ _ _ _

City: _____ State: ____ ZIP Code: _____

Relationship: ☐Spouse ☐Other: _____

Percentage of total benefit to be paid to the above person. _____%.

****

Name: _____ Social Security # _ _ _-_ _ -_ _ _ _

Address: _____ Date of Birth: _ _ /_ _ /_ _ _ _

City: _____ State: ____ ZIP Code: _____

Relationship: _____

Percentage of total benefit to be paid to the above person. _____%.

****

Name: _____ Social Security # _ _ _-_ _ -_ _ _ _

Address: _____ Date of Birth: _ _ /_ _ /_ _ _ _

City: _____ State: ____ ZIP Code: _____

Relationship: _____

Percentage of total benefit to be paid to the above person. _____%.

Contingent Beneficiaries

In the event there are no Primary Beneficiaries, I name the following as my Contingent Beneficiary(ies):

Name: _____ Social Security # _ _ _-_ _ -_ _ _ _

Address: _____ Date of Birth: _ _ /_ _ /_ _ _ _

City: _____ State: ____ ZIP Code: _____

Relationship: _____

Percentage of total benefit to be paid to the above person. _____%.

****

Name: _____ Social Security # _ _ _-_ _ -_ _ _ _

Address: _____ Date of Birth: _ _ /_ _ /_ _ _ _

City: _____ State: ____ ZIP Code: _____

Relationship: _____

Percentage of total benefit to be paid to the above person. _____%.

****

Name: _____ Social Security # _ _ _-_ _ -_ _ _ _

Address: _____ Date of Birth: _ _ /_ _ /_ _ _ _

City: _____ State: ____ ZIP Code: _____

Relationship: _____

Percentage of total benefit to be paid to the above person. _____%.

Part III. Participant Acknowledgement: By signing this Beneficiary Designation Form, I acknowledge and authorize the payment of my vested account balance in the MICHEL BABAJANIAN, MD, FACS, INC., 401(k) PROFIT SHARING PLAN, in the event of my death to the person or persons named herein. I further acknowledge that this designation will remain in effect until a new Beneficiary Designation Form is filed with the Plan Administrator.

I certify that I am ☐ Married ☐ Single and acknowledge that I understand the Spousal Consent provisions of the Plan.

_____ _ _ /_ _ /_ _ _ _

Participant Signature Date

If you are married, and have not named your Spouse as your Primary Beneficiary, who is entitled to 100% of your account balance, you must have your Spouse Consent for the designation that you have made. Your Spouse's signature must be notarized or witnessed by the Plan Administrator.

Part IV. Spousal Consent: I hereby approve of, and consent to the above Beneficiary Designation in the MICHEL BABAJANIAN, MD, FACS, INC., 401(k) PROFIT SHARING PLAN ("the Plan"). I understand the effect of this election and hereby waive my right to receive the benefit that would otherwise be payable under the Plan.

_____ _ _ /_ _ /_ _ _ _

Spouse Signature Date

Notary Certification

I, _____, a Notary Public, do hereby certify

that on this _____ day of _____, _____ before me

came _____, whose signature is subscribed above, and that he/she did in my presence execute the Spousal Consent and Waiver, having acknowledged to me that he/she did so as a free and voluntarily consents to this non-spousal Beneficiary Designation. I hereby acknowledge this signature as belonging to the above named individual.

_____ My Commission Expires: _ _ /_ _ /_ _ _ _
Notary Public

SEAL
in and for the County of _____, State of _____

Part V. Plan Administrator Acknowledgement: I hereby acknowledge receipt of this Beneficiary Designation Form and the accuracy of the Employee Information.

_____ _ _ /_ _ /_ _ _ _
Plan Administrator Signature Date