TRANSAMERICA®
Retirement Solutions

TRINITY HEALTH
Livonia, Michigan

Beneficiary Designations

Instructions **For internal use only: TT069026 TT069066 TT080181 TT080182 TT080202 TI097382 TQ097383 TO097648 TT069478**

To designate a beneficiary or to change your existing beneficiary designation(s) on all of the Trinity Health Retirement Plans, including the 403(b) Retirement Savings Plan TT069026, the 403(b) Retirement Savings Plan (After-Tax) TT069066, the 401(k) Retirement Savings Plan TT080181, the 401(k) Retirement Savings Plan (Frozen) TT080182, the 401(k) Retirement Savings Plan (After-Tax) TT080202, the 457(b) Deferred Compensation Plan for Tax Exempt Organizations TI097382, the Deferred Compensation Plan for Taxable Entities TQ097383 TO097648 – Trinity Health, Novi, Michigan 457(f) Deferred Compensation Plan, and the TT069478 – Trinity Health Corporation ERISA 403(b) Retirement Plan (Frozen) as applicable, complete all applicable sections of this form and return it to Transamerica at 4333 Edgewood Road NE, Mail Drop 0001, Cedar Rapids, IA 52499. If you have questions or need assistance completing this form, please contact your local on-site Retirement Plan Specialist, or call us at 800-394-5240. ***Please note: You must complete this form and it must be received by Transamerica in order for the designation to be valid.***

LEVEL 3

Section A. Employer Information

Company/Employer Name

Contract/Account No. Affiliate No. Division No.

Section B. Personal Information

Social Security No. Date of Birth (mm/dd/yyyy)

First Name/Middle Initial Last Name

Mailing Address

City State Zip Code

Phone No. Ext.

E-mail Address

Section C. Primary Beneficiary Designation - Will receive benefits in the event of your death

This designation will apply to the account number above. You must designate a specific percentage for each beneficiary. Shares must be whole percentages and total 100%. If you do not indicate shares, benefits will be split equally among surviving beneficiaries. If the named beneficiary is a trust, please specify the name and date of the trust, and the name of the trustee.

If you are married, you must designate your spouse as your primary beneficiary for 100% of the death benefit. If you wish to designate less than 100% of the death benefit to your spouse, please complete Section E. and F.

Note: Share of benefits must total 100% for primary beneficiaries. If additional space is needed to designate multiple beneficiaries, complete the Supplemental Beneficiary Designation page.

Share of Benefits: % (whole percentages only) Relationship

Last Name Date of Birth (mm/dd/yyyy)

First Name/Middle Initial Social Security No.

Mailing Address

City State Zip Code

PLEASE COMPLETE SECTION G ON PAGE 3 - THIS IS REQUIRED FOR ALL PARTICIPANTS

Section C. Primary Beneficiary Designation (continued)

Share of Benefits: ______ % (whole percentages only) Relationship ______

Last Name ______ Date of Birth (mm/dd/yyyy) ______

First Name/Middle Initial ______ Social Security No. ______

Mailing Address ______

City ______ State ______ Zip Code ______

Section D. Contingent Beneficiary(ies) - Will receive benefits if no primary beneficiary is living at the time of your death

Note: Share of benefits must total 100% for contingent beneficiaries. If additional space is needed to designate multiple beneficiaries, complete the Supplemental Beneficiary Designation page.

Share of Benefits: ______ % (whole percentages only) Relationship ______

Last Name ______ Date of Birth (mm/dd/yyyy) ______

First Name/Middle Initial ______ Social Security No. ______

Mailing Address ______

City ______ State ______ Zip Code ______

Share of Benefits: ______ % (whole percentages only) Relationship ______

Last Name ______ Date of Birth (mm/dd/yyyy) ______

First Name/Middle Initial ______ Social Security No. ______

Mailing Address ______

City ______ State ______ Zip Code ______

PLEASE COMPLETE SECTION G ON PAGE 3 - THIS IS REQUIRED FOR ALL PARTICIPANTS

Section E. Notice and Waiver of Pre-Retirement Survivor Benefit
(for married participants if spouse is not primary beneficiary for 100% of account balance):

As a plan participant, the law requires that you be informed as to the disposition of your account. In the case of your death before retirement, the plan will pay your full vested account balance to your surviving spouse. However, you may elect to waive the requirement that your death benefit be paid to your surviving spouse. Your spouse must consent in writing to any such waiver. You may revoke any waiver at any time before your death, and, if you desire, make a new election, provided your spouse consents to this new election. If you elect that your spouse is not to be your beneficiary for your full vested account balance (and your spouse has consented), then you may designate a beneficiary of your choosing. If you are not married at the time of your death, the death benefit will be paid to your designated beneficiary.

I have been informed that if I should die prior to my retirement, I have the right to have the full vested account balance in the plan paid to my spouse; that I have the right to waive the designation of my spouse as the beneficiary of all or a portion of my death benefit only if my spouse consents to such waiver; and that I have the right to revoke such waiver at any time without my spouse's consent. I hereby waive the right to have my spouse be the beneficiary of all or a portion of my pre-retirement death benefit. Instead I designate the beneficiary(ies) indicated in Section C.

X____ **X**________________

Participant Signature Date

Section F. Spousal Consent (if spouse is not primary beneficiary for 100% of account balance)

I consent to my spouse's waiver of my rights to all or a portion of the qualified pre-retirement survivor annuity death benefit coverage. I understand that this consent means I may not receive any (or only a portion) of my spouse's retirement benefits under the plan in the event of my spouse's death prior to payment of benefits under the plan. Instead I agree to the above designation of beneficiary(ies) to receive all or a portion of benefits upon my spouse's death. I further understand that if my spouse wishes to change the above beneficiary designation, my written consent will be required.

X____ **X**________________

Spouse Signature Date

WITNESSED

X____ **X**________________

Notary Public Signature and Stamp/Seal Date

PLEASE COMPLETE SECTION G - THIS IS REQUIRED FOR ALL PARTICIPANTS

Section G. Participant Signature

I certify that the information provided on this form is correct and complete.

X____ **X**________________

Participant Signature Date

X____ **X**____

Print Name Social Security Number

Supplemental Beneficiary Designations

Social Security No. ____________________

First Name/Middle Initial ____________________ Last Name ____________________

Note: Share of benefits must total 100% for primary beneficiaries *(will receive benefits in the event of your death)* **AND *100% for contingent beneficiaries*** (*will receive benefits if no primary beneficiary is living at the time of your death).*

☐ **Primary Beneficiary** ☐ **Contingent Beneficiary**

Share of Benefits: ______ % (whole percentages only) Relationship ____________________

Last Name ____________________ Date of Birth (mm/dd/yyyy) ____________________

First Name/Middle Initial ____________________ Social Security No. ____________________

Mailing Address ____________________

City ____________________ State __________ Zip Code __________

☐ **Primary Beneficiary** ☐ **Contingent Beneficiary**

Share of Benefits: ______ % (whole percentages only) Relationship ____________________

Last Name ____________________ Date of Birth (mm/dd/yyyy) ____________________

First Name/Middle Initial ____________________ Social Security No. ____________________

Mailing Address ____________________

City ____________________ State __________ Zip Code __________