



Beneficiary Designation Governmental 457(b) Plan

State of Tennessee 457 Plan

98986-01

Participant Information

| | | | |
|----------------|------------|----|------------------------|
| Last Name | First Name | MI | Social Security Number |
| E-Mail Address | | | |

This designation supersedes all prior designations. Beneficiaries will share equally if percentages are not provided and any amounts unpaid upon death will be divided equally. Primary and contingent beneficiaries must separately total 100.00%.

Primary Beneficiary

| # | % of Account Balance | Social Security Number | Primary Beneficiary Name | Relationship | Date of Birth |
|----|----------------------|------------------------|--------------------------|--------------|---------------|
| #1 | . | | | | |
| #2 | . | | | | |
| #3 | . | | | | |

Contingent Beneficiary

| # | % of Account Balance | Social Security Number | Contingent Beneficiary Name | Relationship | Date of Birth |
|----|----------------------|------------------------|-----------------------------|--------------|---------------|
| #1 | . | | | | |
| #2 | . | | | | |
| #3 | . | | | | |

Plan Beneficiary Designation

This designation is effective upon execution and delivery to Service Provider at the address below. If I name more than one beneficiary in either category, the surviving beneficiaries in that category will share equally unless otherwise indicated. I have the right to change the beneficiary. If any information is missing, additional information may be required prior to recording my beneficiary designation. If my primary and contingent beneficiaries predecease me or I fail to designate beneficiaries, amounts will be paid pursuant to the terms of the Plan Document or applicable state law.



Last Name

First Name

MI

Social Security Number

Required Signature(s) and Date

Participant Consent

I have completed, understand and agree to all pages of this Beneficiary Designation form. I understand that Service Provider is required to comply with the regulations and requirements of the Office of Foreign Assets Control, Department of the Treasury ("OFAC"). As a result, Service Provider cannot conduct business with persons in a blocked country or any person designated by OFAC as a specially designated national or blocked person. For more information, please access the OFAC Web site at <http://www.ustreas.gov/offices/eotffc/ofac>.

Participant Signature

Date

Participant forward to Service Provider at:

Great-West Retirement Services®
PO Box 173764, Denver, CO 80217-3764

Express Address:

8515 E. Orchard Road, Greenwood Village, CO 80111

Phone #: 1-800-922-7772

Fax #: 1-866-745-5766

Statement of Notary

State of _____) The above election was subscribed before me by _____

) ss. on this _____ day of _____, year _____, who

SEAL

County of _____) affirmed that such election represents his/her free and voluntary act.

Notary Public _____ My commission expires: _____

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