



STATE OF DELAWARE
OFFICE OF PENSIONS

BURIAL BENEFIT
DESIGNATION FORM

PLEASE COMPLETE AND RETURN FORM TO THE OFFICE OF PENSIONS

Name (Print): Member ID or SSN:

Please complete form in its entirety and return to Pension Office. Incomplete forms will be rejected.

State Employees'
(Retiree Only)

New State Police
(Retiree Only)

Closed State Police
(Retiree Only)

Legislators'
(Retiree Only)

County and Municipal Police
and Firefighters'
(Only applies to members
actively employed upon death)

Primary Gender: M F
Full Name of Individual, Funeral Home or Organization:
Date of Birth: SSN / EIN: Relationship:
Mailing Address:
Optional Contact Information (Telephone/Email):

Primary Secondary (Choose one - Secondary receives money if Primary deceased) Gender: M F
Full Name of Individual, Funeral Home or Organization:
Date of Birth: SSN / EIN: Relationship:
Mailing Address:
Optional Contact Information (Telephone/Email):

Primary Secondary (Choose one - Secondary receives money if Primary deceased) Gender: M F
Full Name of Individual, Funeral Home or Organization:
Date of Birth: SSN / EIN: Relationship:
Mailing Address:
Optional Contact Information (Telephone/Email):

I hereby direct that any amount of burial benefit payable at my death be paid to the Beneficiary(ies) designated above, if living. I understand that if more than one Beneficiary is designated, payment will be made in equal shares to each of the designated Beneficiary(ies) as survive me, unless otherwise specified herein.

THIS FORM REVOKES ALL PREVIOUS BENEFICIARY DESIGNATIONS.

All beneficiaries must be restated even if they are not being changed. For example, if you are changing only the secondary beneficiary, you must also restate the primary beneficiary.

X SIGNATURE

TELEPHONE NUMBER

For Use by Notary Public Only
Sworn to and subscribed before me this day of
, 20.
Signature of Notary Public

Place Notary Stamp Here