

# MUTUAL OF AMERICA

## Beneficiary Designation Form

*It's important to keep your beneficiary designations current.*



To Add or Change Beneficiaries for Your Mutual of America Contracts:

- 1.** Complete and sign the Beneficiary Designation Form.
- 2.** For those contracts subject to the spousal waiver, have your spouse complete and sign the Spouse's Waiver in the presence of a Notary or Authorized Representative of your employer.
- 3.** If you are designating a Trust as Beneficiary OR if you are required to provide an Irrevocable Designation of Beneficiary, contact Mutual of America using the address and phone number below.
- 4.** Send the completed, signed form to Mutual of America at the following address:

**MUTUAL OF AMERICA LIFE INSURANCE COMPANY**  
**Three Lakeway Center**  
**3838 North Causeway Boulevard**  
**Suite 3100**  
**Metairie, LA 70002-8342**  
**(504) 832-9055**

If you have any questions, please call a Mutual of America representative at the number listed above weekdays between 8:00 AM and 5:00 PM local time or, toll free, at 1-800-468-3785, weekdays between 9:00 AM and 9:00 PM Eastern Time.

- If you are designating a Trust, you must use Mutual of America’s “Designation of Trust as Beneficiary” Form 6475.  
(To the Employer: Trust designations cannot be processed through Hotline.)
- IF THIS DESIGNATION APPLIES TO A NEW ENROLLMENT, IT MUST BE DATED ON OR AFTER THE DATE ON THE ENROLLMENT FORM. If you are now enrolling in a plan, employer’s name and mailing address below may be left blank.
- For the plans indicated, THIS DESIGNATION COMPLETELY REPLACES ANY PREVIOUS BENEFICIARY DESIGNATION.

EMPLOYER’S NAME				EMPLOYER NUMBER	
CUSTOMER IDENTIFICATION NUMBER	PARTICIPANT’S NAME	First	Initial	Last	<input type="checkbox"/> MARRIED <input type="checkbox"/> UNMARRIED (Single, Widowed or Divorced)
MAILING ADDRESS	Street and Number (Include Apartment Number)			City	State    Zip Code
IF FOREIGN RESIDENT	Province				Country
					DAY TELEPHONE NUMBER (    )

**I wish to designate one or more beneficiaries under:**

- All my group coverages with current and prior Employers, and all SEP, IRA, VUL and FPA Programs.
- Only the coverages listed below:

Type of Plan (Pension, TDA, etc.)	Employer/Plan Number
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Spouse’s Waiver on reverse must be completed if participant is married and designating a primary beneficiary other than a spouse for the following plan types: Defined Contribution Pension, Thrift, 401(k), certain TDA plans (check Summary Plan Description), and VEC (Voluntary Employee Contributions).

Married Defined Benefit Plan Participants must designate their spouse as primary beneficiary. The spouse of a Defined Benefit Plan participant cannot waive their right to be named as primary beneficiary.

**To Employer using Hotline:** After entering data, you must send this form to your Service Manager for any SEP, IRA or FPA plan. Retain a copy for your files. Designation is pending until Mutual receives form.

**BENEFICIARY DESIGNATIONS (Complete Reverse Side)**

In the event of your death, and subject to the Eligible Spouse Waiver requirements, the total value of your account will be paid to the person or persons you name as your primary beneficiary. If no one you have named as a primary beneficiary survives you, the person(s) you name as your secondary beneficiary will receive the death benefit. If there is no living designated beneficiary at your death, the amount payable will be paid to the first surviving class of the following: (a) your surviving spouse (as determined under state law), (b) your surviving children in equal shares, (c) your surviving parents in equal shares, (d) your surviving brothers and sisters in equal shares, or (e) the executors or administrators of your estate.

If you name more than one primary beneficiary, or more than one secondary beneficiary, the death benefit will be paid in equal shares to the primary beneficiaries who survive you, or if none, to the secondary beneficiaries who survive you, unless you show below the percentage you want each of them to receive. If you specify percentages you want each beneficiary to receive, be sure your percentages for all beneficiaries in each beneficiary type total 100%.

Name your primary and secondary beneficiaries in the space provided on the reverse side. If you need more space, attach a page providing the information asked for each beneficiary. Please add your name, the last four digits of your Social Security number, signature and the date.

## BENEFICIARY DESIGNATIONS

<b>Beneficiary Type:</b> <input checked="" type="checkbox"/> Primary				<b>Beneficiary Type:</b> <input type="checkbox"/> Primary <input type="checkbox"/> Secondary			
<b>Relationship:</b> <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Estate <input type="checkbox"/> Other				<b>Relationship:</b> <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Estate <input type="checkbox"/> Other			
FULL NAME First Initial Last			FULL NAME First Initial Last				
DATE OF BIRTH / /	SOCIAL SECURITY #	PHONE # ( )	DATE OF BIRTH / /	SOCIAL SECURITY #	PHONE # ( )		
ADDRESS Street			ADDRESS Street				
City		State Zip Code	City		State Zip Code		
IF FOREIGN RESIDENT Province Country		BENEFIT PERCENT %	IF FOREIGN RESIDENT Province Country		BENEFIT PERCENT %		

<b>Beneficiary Type:</b> <input type="checkbox"/> Primary <input type="checkbox"/> Secondary				<b>Beneficiary Type:</b> <input type="checkbox"/> Primary <input type="checkbox"/> Secondary			
<b>Relationship:</b> <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Estate <input type="checkbox"/> Other				<b>Relationship:</b> <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Estate <input type="checkbox"/> Other			
FULL NAME First Initial Last			FULL NAME First Initial Last				
DATE OF BIRTH / /	SOCIAL SECURITY #	PHONE # ( )	DATE OF BIRTH / /	SOCIAL SECURITY #	PHONE # ( )		
ADDRESS Street			ADDRESS Street				
City		State Zip Code	City		State Zip Code		
IF FOREIGN RESIDENT Province Country		BENEFIT PERCENT %	IF FOREIGN RESIDENT Province Country		BENEFIT PERCENT %		

## PARTICIPANT'S SIGNATURE

(FOR NEW ENROLLMENT, YOU MUST SIGN AND DATE ON OR AFTER THE DATE ON ENROLLMENT FORM.)

SIGNATURE	DATE / /
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## SPOUSE'S WAIVER (Witnessed by a Notary Public or Authorized Representative of Employer)

My spouse is a participant in a Mutual of America Plan under which I am entitled to be the beneficiary. As such, I would receive the total death benefit after my spouse's death. However, I agree to waive my right to be the beneficiary. I agree to let my spouse designate the beneficiary or beneficiaries named on this form. My spouse may withdraw this designation at any time but may not designate a different primary beneficiary without my consent.

\_\_\_\_\_  
SIGNATURE OF SPOUSE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE AND SEAL OF NOTARY PUBLIC OR SIGNATURE OF AUTHORIZED REPRESENTATIVE

\_\_\_\_\_  
DATE

**Note:** At the discretion of the Notary, an acknowledgement form may be stapled to this form.  
The Spouse's Waiver is invalid for Defined Benefit Plan participants.

### For Mutual of America Use Only

MUTUAL OF AMERICA'S CONFIRMATION (if applicable)	SIGNATURE	DATE / /
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