



**Death Benefit Designation**  
**\$5000 Death Benefit from Kentucky Public Pensions Authority**

**Notice: This properly completed form must be received at Kentucky Public Pensions Authority before your death to be valid.**

To be eligible for this benefit, you must be a retired member receiving a monthly benefit on the date of your death from Kentucky Public Pensions Authority based on a minimum of 48 months of service.

**Member Information** Please provide your Member ID or Social Security Number in the Member ID box below.

Member Name:		Member ID:	
Address:	City:	State:	Zip Code:
Phone (select type) <input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work		Email:	

**You may name one death benefit beneficiary. Please check only one box below.**

Please complete the necessary information and provide the requested documentation with this form. Failure to complete this form properly or provide the requested documentation may invalidate the form. Your estate will become your default beneficiary if this form is deemed to be invalid.

**Person**

You may only name one person as your death benefit beneficiary.

Beneficiary Name:		Beneficiary Social Security Number:	
Beneficiary Date of Birth:	Relationship to Member:	<input type="radio"/> Male	<input type="radio"/> Female
Address:	City:	State:	Zip Code:

**My Estate**

No additional information required.

**Living Trust**

The following information is required to designate a living trust. You must write the name of the trust as it appears in the trust document and submit a copy of the trust with this form. A charitable organization or a religious charity cannot be named as beneficiary unless it is a trust.

Name of Trust:		Trust Tax ID:	
Trustee or Successor Trustee Contact Information: Our office will contact the trustee listed below following your death.			
Name of Trustee:		Successor Trustee (if applicable):	
Trustee Address:	City:	State:	Zip Code:


**Testamentary Trust**

A testamentary trust is established by the member's will and takes effect following the member's death. No additional information required.

**Funeral Home**

Please enclose a copy of the Funeral Home License.

Funeral Home Legal Name:		Funeral Home License Number:	
Funeral Home Tax ID:	Contact Name:	Phone:	
Address:	City:	State:	Zip Code:

 **You may only designate ONE beneficiary. This form is not valid if you designate more than one beneficiary. This form is not valid unless signed by the member and witnessed. Please initial all corrections you have made to the form. Failure to initial changes may cause the form to be invalid.**

Your Signature:	Member ID:
Spouse Signature: (Not Required)	Date:
Witness Signature: (Required if Spouse does not sign)	Date: