Denbright Dental Labs 401(k) Plan
BENEFICIARY DESIGNATION FORM

As a Participant in the Plan, you must designate a beneficiary or beneficiaries on this form who will receive a distribution of your benefit in the event of your death. You may change your beneficiary designation at any time (such as following a change in marital status, birth of a child, etc.) by completing a new Beneficiary Designation Form.

Complete all applicable sections on both pages of this form in Blue or Black ink and PRINT clearly. Your signature as the Participant is required in Part 4 on page 2 before the form is submitted.

Part 1 PARTICIPANT INFORMATION			
Participant Name (Last, First, MI)			Social Security Number
Street Address			Date of Birth
City	State	Zip Code	Date of Hire
Daytime Phone Number	Email Address		Company Division or Location

Current Marital Status ***(check one box):***

☐ **I Am Legally Married.** I understand that my spouse will be my sole primary beneficiary and should be named as receiving 100% of my benefit in Part 2. If I want to designate a primary beneficiary other than, or in addition to, my spouse, then my spouse must consent to this election in Part 3 below and this consent must be witnessed by a Plan Representative or Notary Public. **NOTE:** *This provision may or may not apply to you if you are a participant in a governmental or non-electing church plan. Check with your Plan Administrator.*

☐ **I Am Not Married.** I understand that if I become married in the future, my spouse will become my primary beneficiary unless I complete a new Beneficiary Designation Form and my spouse consents to my designation in writing.

Part 2 BENEFICIARY DESIGNATION

Fill in your primary and contingent beneficiary information below. If you want to designate more than two primary or contingent beneficiaries, attach an additional form(s). The percent of distribution for all primary beneficiaries must be in whole percentages and total 100%, as is the case for contingent beneficiaries. Contingent beneficiaries receive distributions only if no primary beneficiaries survive you. Should one or more primary beneficiaries predecease you and you do not complete an updated Beneficiary Designation Form, the distribution percentages will be recalculated among the remaining primary beneficiaries based on your most current designation. The same methodology is used for contingent beneficiaries. The designations below shall supersede any and all prior beneficiary designations.

PRIMARY BENEFICIARY (ies) – REQUIRED – All information must be completed for each Beneficiary.

Beneficiary Name: (Last, First, MI)			Relationship to Participant	
Street Address			Social Security Number	
City	State	Zip Code	Date of Birth	% of Distribution
Beneficiary Name: (Last, First, MI)			Relationship to Participant	
Street Address			Social Security Number	
City	State	Zip Code	Date of Birth	% of Distribution

Must be in whole %'s and TOTAL 100%

Part 2 BENEFICIARY DESIGNATION (continued from Page 1)

Note: Contingent beneficiaries receive distributions only if no primary beneficiaries survive you.

CONTINGENT BENEFICIARY (ies) – OPTIONAL - All information must be completed for each Beneficiary.

Beneficiary Name: (Last, First, MI)			Relationship to Participant	
Street Address			Social Security Number	
City	State	Zip Code	Date of Birth	% of Distribution
Beneficiary Name: (Last, First, MI)			Relationship to Participant	
Street Address			Social Security Number	
City	State	Zip Code	Date of Birth	% of Distribution

Must be in whole %'s and TOTAL 100%

Part 3 SPOUSAL CONSENT *(Complete ONLY if spouse is NOT the sole primary beneficiary)*

As the spouse of the Participant named in Part 1, I consent to have my spouse's benefit paid to the beneficiary(ies) specified in Part 2. The Plan's death benefit provisions have been explained to me and I understand the following:

(1) The effect of the designation is to cause all or a portion of my spouse's benefit to be paid to a beneficiary other than me

(2) Each beneficiary designation is not valid without my consent in writing

(3) My consent is irrevocable unless my spouse revokes the beneficiary designation to which I have consented in this Part 3

Name of Participant's Spouse (Please PRINT)		
Signature of Participant's Spouse		Date
Signature of Plan Representative or Notary Public	Date Witnessed	Date My Commission Expires
Notary Seal		

Part 4 PARTICIPANT AUTHORIZATION (REQUIRED)

As the Participant in the Plan, I revoke any previous beneficiary designations and specify the above-named beneficiary(ies).

_____ _____

Participant Signature Date

If you have any questions, please call the USICG Participant Service Center at (866) 305-8846, Plan Code **713**

After completing this request, return it for processing using one of the options below:

Mail: Denbright Dental Labs - Attn: Griselda Castellanos – 1108 Investment Blvd. El Dorado Hills, CA 95762

Email: griselda@denbright.com

Please make a copy of this form for your records