Health & Financial Benefits
HEALTHY LIVING. HEALTHY FUTURE.

City of Portland -
457 Deferred Compensation Plan - Beneficiary/Trust Designation

Instructions: Complete all required fields and click the Participant Signature field to insert your electronic signature. Save a copy of your completed form, then click the Submit button to email.
No email? Print and interoffice to: BHR/106/987 or mail to 1120 SW 5th Ave Room 987, Portland OR 97204.

Section 1: Employee (Plan Holder) Information:

First Name: Last Name: Date of Birth:

Address: City: State: Zip Code:

Primary Phone: Work Phone: Interoffice Address:

Section 2: Beneficiary Information: I hereby designate the following individual(s) or organization(s) as my beneficiary(ies) to receive in the proportions indicated any benefits which may become due or payable on or after my death under my Deferred Compensation Agreement. Percentages for primary / contingent beneficiaries must each equal 100%.

Beneficiary Type: Primary ☐ Contingent ☐ Percentage: Relationship:

Name: Date of Birth (person) / Tax ID (trust):

Address: City: State: Zip Code:

Beneficiary Type: Primary ☐ Contingent ☐ Percentage: Relationship:

Name: Date of Birth (person) / Tax ID (trust):

Address: City: State: Zip Code:

Beneficiary Type: Primary ☐ Contingent ☐ Percentage: Relationship:

Name: Date of Birth (person) / Tax ID (trust):

Address: City: State: Zip Code:

Beneficiary Type: Primary ☐ Contingent ☐ Percentage: Relationship:

Name: Date of Birth (person) / Tax ID (trust):

Address: City: State: Zip Code:

Section 3: Certification: I hereby reserve the right to change or revoke this beneficiary designation without notice to any beneficiary. In the event that more than one Designation of Beneficiary is executed by me, the latest in time shall govern.

Employee Signature: Date:

SUBMIT