



**DEFINED CONTRIBUTION ENTITLEMENT DOCUMENTS CHECKLIST**

Service Award Plan Name \_\_\_\_\_

Deceased Member \_\_\_\_\_

Member Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Dear Trustees:**

**Please check one of the following options**

The above member has earned credit for 20\_\_

The above member has not earned credit for 20\_\_

\_\_\_\_\_  
Trustee Signature

**The following items should be completed and returned to:**

Marcey Miller  
LOSAP Administrator  
McNeil and Company  
20 Church Street  
PO Box 5670  
Cortland, NY 13045

**Original signed Beneficiary Designation form  
Certified Copy of Death Certificate  
Claimants form**



### SERVICE AWARD PROGRAM BENEFICIARY DESIGNATION

Fire Department Service Award Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

Name of Member/Participant: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby designate as Primary Beneficiary and Secondary Beneficiary:

**\*\* Please print clearly. All blanks must be filled in.**

#### Primary Beneficiary(ies)

Name and Address	Relationship	D.O.B.	Percentage %

**Percentage must total 100%**

#### Secondary Beneficiary(ies)

The Beneficiary(ies) who will receive the proceeds if the Primary Beneficiary has pre-deceased the Participant.

Name and Address	Relationship	D.O.B.	Percentage %

**Percentage must total 100%**

New York Insurance Law Section 4216(b)(7) prohibits naming any organization or association of uniformed firemen, volunteer firefighters or volunteer ambulance workers, the commanding officer, or any of its officials as beneficiary of benefits to be paid under this policy.

\_\_\_\_\_  
Address of Member/Participant

\_\_\_\_\_  
Signature of Member/Participant

\_\_\_\_\_  
Date Signed

#### General Conditions of Designation

This Designation of Beneficiaries may be changed by filling out a new Designation. No Designation shall be effective unless filed with the Company (or Sponsor if Service Award Program). Where more than one Primary Beneficiary has been designated, distribution will be made in equal amounts among those Primary Beneficiaries who are alive at the time of the member's/participant's death, unless otherwise indicated. If the designated Primary Beneficiary is not alive at the time of the member's/participant's death his or her share will be added to the share of each surviving Primary Beneficiary in proportion to the share that each surviving Primary Beneficiary bears to the total share of all surviving Primary Beneficiaries. If no Primary Beneficiary is alive at the time of the member's/participant's death. Distribution will be made on the same basis to designated Secondary Beneficiaries.

***"Comprehensive LOSAP Management"***  
**(800) 822-3747**



**Length of Service Award Distribution Form**

Plan Name: \_\_\_\_\_

**Participant Information:**

Name: \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
First, Middle, Last Name

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

**Beneficiary/Claimant:**

Name: \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
First, Middle, Last Name

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Day phone: ( ) \_\_\_\_\_ Evening Phone: ( ) \_\_\_\_\_

**Distribution Amount: Balance of Service Award Account**

**Income Tax Withholding:**

\_\_\_\_\_ Do not withhold federal income tax from my distribution

\_\_\_\_\_ Withhold 20% federal income tax or \_\_\_\_\_% from my distribution