

STATE OF ARIZONA SUPPLEMENTAL FORM FOR BENEFICIARIES AND DEPENDENTS

EMPLOYEE IDENTIFICATION

LAST NAME, FIRST NAME		EMPLOYEE ID NUMBER	DATE OF EMPLOYMENT
STREET ADDRESS		CITY, STATE	ZIP CODE
HOME TELEPHONE	WORK TELEPHONE	AGENCY NAME	AGENCY CODE

ADDITIONAL BENEFICIARIES

01 LAST NAME, FIRST NAME	STREET ADDRESS	CITY, STATE	ZIP CODE
<input type="checkbox"/> PRIMARY BENEFICIARY <input type="checkbox"/> CONTINGENT BENEFICIARY	% OF FUNDS	PHONE NUMBER	
01 LAST NAME, FIRST NAME	STREET ADDRESS	CITY, STATE	ZIP CODE
<input type="checkbox"/> PRIMARY BENEFICIARY <input type="checkbox"/> CONTINGENT BENEFICIARY	% OF FUNDS	PHONE NUMBER	
01 LAST NAME, FIRST NAME	STREET ADDRESS	CITY, STATE	ZIP CODE
<input type="checkbox"/> PRIMARY BENEFICIARY <input type="checkbox"/> CONTINGENT BENEFICIARY	% OF FUNDS	PHONE NUMBER	
01 LAST NAME, FIRST NAME	STREET ADDRESS	CITY, STATE	ZIP CODE
<input type="checkbox"/> PRIMARY BENEFICIARY <input type="checkbox"/> CONTINGENT BENEFICIARY	% OF FUNDS	PHONE NUMBER	

TRUST OR LEGAL AGREEMENT

NAME OF TRUST, WILL OR LEGAL AGREEMENT		
ADDRESS WHERE FILED	CITY, STATE	ZIP CODE
DATE OF TRUST		

ADDITIONAL DEPENDENTS

LAST NAME, FIRST NAME	MEDICARE A= Medicare A B= Medicare B C=Medicare A&B D=No Medicare E=Medicare Unknown	BIRTH DATE	RELATIONSHIP C=Child G=Guardian P=Placed for adoption T=Stepchild	MALE OR FEMALE	FULL TIME STUDENT Y or N	DISABLED Y or N

I hereby certify under penalty of perjury that the information I have provided in this application for employee benefits, including spouse/dependent information is true and correct. I further acknowledge that I am aware that providing false information may subject me to a denial of employee benefits disciplinary action and potential prosecution pursuant to ARS 13-2310, 12-2702 and other applicable provisions of the law.

EMPLOYEE SIGNATURE _____

DATE _____