

Department of State Treasurer, Retirement Systems Division
3200 Atlantic Avenue • Raleigh, NC 27604 • web: www.myncretirement.com
phone: 877-NC-SECURE (877-627-3287) • fax: 919-855-5800



Complete all sections of this form and read the attached Guides. After completing and signing this form before a notary public, send it to the address above. This form is not valid until it has been properly completed, notarized, and received by our office **prior to your death**. Forms submitted with erasures, strike overs, or white-outs in Sections C through F will not be accepted.

Section A. Tell us about yourself.					<input type="checkbox"/> Check if there are any changes to your contact information.
First Name	M.I.	Last Name	Suffix	SSN (Last 4 digits)	
Mailing Address				Member ID	
City	State	Zip Code	Telephone	Date of Birth	

Section B. Please tell us your retirement system and employer.	
<input type="checkbox"/> Teachers' and State Employees' Retirement System (TSERS) <input type="checkbox"/> Consolidated Judicial Retirement System (CJRS) <input checked="" type="checkbox"/> Local Governmental Employees' Retirement System (LGERS) <input type="checkbox"/> Legislative Retirement System (LRS)	Current Employer 91601 - CARTERET COUNTY

Section C. Select your beneficiary(ies). <i>See Guides for assistance. *REQUIRED FIELD</i>						
1	First Name*	M.I.	Last Name*	Date of Birth*		Select a Benefit (<i>Select one or both</i>) <input type="checkbox"/> Death Benefit <input type="checkbox"/> Return of Contributions Select a Beneficiary Type (<i>Select one</i>) <input type="checkbox"/> Principal <input type="checkbox"/> Contingent
	Address		City	State	ZIP	
	Relationship			Social Security Number*		
	E-Mail Address			Telephone Number		
2	First Name*	M.I.	Last Name*	Date of Birth*		Select a Benefit (<i>Select one or both</i>) <input type="checkbox"/> Death Benefit <input type="checkbox"/> Return of Contributions Select a Beneficiary Type (<i>Select one</i>) <input type="checkbox"/> Principal <input type="checkbox"/> Contingent
	Address		City	State	ZIP	
	Relationship			Social Security Number*		
	E-Mail Address			Telephone Number.		

If you are designating more beneficiaries, check the box at left and complete Page 2. ***REQUIRED FIELD**

Section D. Certify your selections.
<p>I hereby authorize the Board of Trustees to make payment(s) to the beneficiary(ies) I have designated on this form. I acknowledge that the payments shall be a complete discharge of any claim and shall constitute a release of the Retirement System from any further obligation on my account. I understand that by completing and signing this form I acknowledge having read the attached Guides. I reserve the right to change the beneficiary(ies) designated on this form in accordance with the information provided. In addition, I understand that the Retirement System will not accept this form with any erasures, strike overs, or white-outs in Sections C through F. I certify by my signature that I have completed this form in its entirety.</p>
<p>Signature _____ Date _____</p>

Section E. Have this form notarized. <i>Improperly notarized forms will not be accepted.</i>
<p>State of _____ County of _____ My Commission Expires _____</p> <p>I, _____, a notary public for said State and County, do hereby certify that _____ personally appeared before me this date and acknowledge the due execution of this form.</p> <p>Witness my hand and official seal this the _____ day of _____, 20_____</p> <p>Signature of Notary _____</p>



Form 2C Continuation Page *Duplicate as Needed*

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This page is intended as a supplement to Page 1, and is optional. If you have more beneficiaries to designate, complete this page and submit with Page 1. Please note that forms submitted with erasures, strike overs, or white-outs in Sections C through F will not be accepted.

Section F. Select your additional beneficiary(ies). (Optional) See Guides for assistance. *REQUIRED FIELD

Please select additional beneficiaries. You do not need to repeat any beneficiaries listed on Page 1.

3	First Name*		M.I.	Last Name*		Date of Birth*		Select a Benefit (<i>Select one or both</i>) <input type="checkbox"/> Death Benefit <input type="checkbox"/> Return of Contributions
	Address			City		State	ZIP	
	Relationship				Social Security Number*			
	E-Mail Address				Telephone Number			
4	First Name*		M.I.	Last Name*		Date of Birth*		Select a Benefit (<i>Select one or both</i>) <input type="checkbox"/> Death Benefit <input type="checkbox"/> Return of Contributions
	Address			City		State	ZIP	
	Relationship				Social Security Number*			
	E-Mail Address				Telephone Number			
5	First Name*		M.I.	Last Name*		Date of Birth*		Select a Benefit (<i>Select one or both</i>) <input type="checkbox"/> Death Benefit <input type="checkbox"/> Return of Contributions
	Address			City		State	ZIP	
	Relationship				Social Security Number*			
	E-Mail Address				Telephone Number			
6	First Name*		M.I.	Last Name*		Date of Birth*		Select a Benefit (<i>Select one or both</i>) <input type="checkbox"/> Death Benefit <input type="checkbox"/> Return of Contributions
	Address			City		State	ZIP	
	Relationship				Social Security Number*			
	E-Mail Address				Telephone Number			

First Name		M.I.	Last Name		Suffix
SSN (Last 4 digits)		Member ID		Date of Birth	

*REQUIRED FIELD