State of Hawaii
PTS Deferred Compensation Retirement Plan

BENEFICIARY CLAIM FORM

Please print all information clearly in ink.

Requesting a distribution from the following Employer:	☐ State of Hawaii	☐ County of _____

NAME OF DECEASED *(full legal name)*	SOCIAL SECURITY NUMBER

Beneficiary Data

LAST NAME OF BENEFICIARY	FIRST NAME	MIDDLE	SOCIAL SECURITY NUMBER
HOME ADDRESS *(street number and name)*			HOME PHONE NUMBER
CITY	STATE	ZIP CODE	BIRTHDATE
RELATIONSHIP TO DECEASED			

I hereby assert a claim to the assets in the above deceased's PTS Deferred Compensation Retirement Plan account. I understand and agree that:

- I must attach a copy of my driver's license or other acceptable identification
- I must attach a certified copy of the death certificate
- The assets will be distributed only by check and in a lump sum

_____ _____
Beneficiary's Signature Date

MAIL COMPLETED FORM TO:
COMPREHENSIVE FINANCIAL PLANNING, INC./LSW
1314 S. KING STREET, SUITE 321
HONOLULU, HI 96814