

DESERT HOSPITAL RETIREMENT PROTECTION PLAN

DESIGNATION OF BENEFICIARY FORM

Participant Information:

Name: _____ Social Security# _____ - ____ - ____

Address: _____

Birth Date: _____

I hereby revoke and cancel all beneficiary designations heretofore made by me under the Desert Hospital Retirement Protection Plan, and I hereby designate the following to be my beneficiary(ies) to receive any post retirement death benefits due upon my death.

Primary Beneficiary

Name: _____ Social Security# _____ - ____ - ____

Address: _____

Relationship: _____ Birth Date: _____

Contingent Beneficiary

Name: _____ Social Security# _____ - ____ - ____

Address: _____

Relationship: _____ Birth Date: _____

Participant's Signature

Date