SICK LEAVE BENEFICIARY DESIGNATION

Plan Name: Caroline County, Maryland Employees Sick Leave Plan

Participant Name: _____

Date: _____

I hereby direct that 100% of all benefits, which are payable upon my death from the County Commissioners of Caroline County Sick Leave Plan shall be paid unto:

_____
Name

_____
Address

_____
City, State, Zip

_____ _____
Relationship Date of Birth

In case of his/her death before me, I designate, as SECONDARY Beneficiary, the following:

_____
Name

_____
Address

_____
City, State, Zip

_____ _____
Relationship Date of Birth

I further understand that the amounts of benefits to which I or my Beneficiary may be entitled are governed by the terms and conditions of the said Caroline County Personnel Rules and Regulations, Section 8-105.G.2.

Signed: _____