CENTRAL MAINE HEALTHCARE CORPORATION 457 PLAN

BENEFICIARY DESIGNATION

EMPLOYEE NAME _____
(LAST) (FIRST) (INITIAL)

SOCIAL SECURITY NUMBER _____

BENEFICIARY DESIGNATION (All participants must complete)

I would like my beneficiary designation as follows:

Primary Beneficiary _____ Relationship _____

_____ _____

Secondary _____ Relationship _____

_____ _____

CERTIFICATION (Complete appropriate parts)

Single Participant - I certify that I am not married. I agree to notify the Plan Administrator in the event I get married. I understand that if I do get married, I must submit a new designation naming my spouse as beneficiary, unless he or she agrees in writing to a different beneficiary.

Date _____ Employee Signature _____

Married Participant - (Check one, and complete spousal agreement if spouse is not designated.)

____ I have named my spouse as primary designation.

____ I have named someone other than my spouse as my primary beneficiary and my spouse agrees to such designation. (Spouse MUST sign spousal agreement below.)

Date _____ Employee Signature _____

SPOUSAL AGREEMENT - (If spouse is not named primary beneficiary)

I certify that I am the spouse of the above-named participant and agree with the beneficiary designation set forth above. I understand that the above designation specifies the only person(s) who will receive any death benefits payable in the event of the death of my spouse.

Date _____ Spouse's Signature _____

I certify that the above-named spouse whose signature appears above personally appeared before me this date to waive his/her rights as primary beneficiary to any death benefits payable upon the death of the participant.

Date _____ _____
Signature and Title of Witness
(Notary Public or Plan Representative)