

Outstanding Wage Beneficiary Designation Form

The Department of Agriculture, Food, & Forestry (ODAFF) #040, Conservation Commission #645, Oklahoma Horse Racing Commission (OHRC) #353 offers its employees the option of designating a beneficiary to receive the employee's final earned wages in the event of an employees' death while an employee.

The purpose of the Outstanding Wage Beneficiary Designation Form is to assist the employee's beneficiaries at the time of death and prevent any unnecessary delay in final payment of any earned wages.

If you elect to name a beneficiary, you must complete this form and submit to the Human Resources. In the event you need to update the beneficiary, **YOU** are required to complete a new form and submit it to Human Resources.

Primary Beneficiary: Receives priority distribution upon the employee's death.

Contingent Beneficiary: Receives distribution **only** if the primary beneficiary or beneficiaries are deceased at the time of the employee's death.

If an employee does not elect to name a beneficiary, the payroll office will issue the employee's final paycheck, including any pay for unused annual, vacation leave in accordance with Title 40, O.S., Section 165.3a, payment of wages to surviving spouse and children. Please be advised that if your final check is processed without the naming of a beneficiary, your surviving spouse or if there is no surviving spouse your dependent children or their guardians or conservators of their estates will receive equal shares up to the maximum of \$3000 allowed by law. Any remaining payment will go into the estate and process through probate. Access to the funds processed through the estate may be delayed due to the probate process.

Employee Full Name: _____ **Employee ID:** _____

Primary Beneficiary:

Full Name: _____ DOB (MM/DD/YYYY): _____

Social Security Number: _____ Relationship: _____

Address: _____
Street City State Zip Code

Beneficiary: Primary: _____ Contingent: _____

Full Name: _____ DOB (MM/DD/YYYY): _____

Social Security Number: _____ Relationship: _____

Address: _____
Street City State Zip Code

Beneficiary: Primary: _____ Contingent: _____

Full Name: _____ DOB (MM/DD/YYYY): _____

Social Security Number: _____ Relationship: _____

Address: _____
Street City State Zip Code

I acknowledge I have read and understand the content of this form and the beneficiary form(s) on file with the most current date supersedes any previously submitted wage beneficiary form(s).

EMPLOYEE SIGNATURE

DATE