Coastal Bend COLLEGE

Part-Time Employees Retirement Plan

The U.S. Congress passed "OBRA 90" legislation that requires all employees of Coastal Bend College (full-time and part-time) to be participating in a retirement plan. This does not include CBC student employees. CBC has two options: either the College could set up a part-time employee retirement plan or all part-time employees would have to participate in Social Security.

Coastal Bend College does not participate in Social Security. The CBC Board of Trustees adopted an alternative retirement plan: each part-time employee will have 6.4% of wages deducted from his/her paycheck and the college will contribute an additional 1.1% of wages.

Each employee will have his/her own account in the plan. This account will receive both the employee's contribution and the contribution of the College. The Plan will invest in funds and income earned by the fund will be allocated to each account.

In addition, be advised that the required 20% will be withheld for Federal Income Tax at the time the funds are distributed at the participant's request.

Instructions for completing the attached Retirement Plan Beneficiary Designation Form:

1. Detach the Retirement Plan Beneficiary Designation Form from this top cover page.
2. Participant must complete the Retirement Plan Beneficiary Designation Form and sign the form in front of a witness who is not related to the Participant.
3. Return the Retirement Plan Beneficiary Designation Form with all other required Employee documents to the CBC Human Resources Office.
4. Keep this top cover page for your records.

Coastal Bend College does not discriminate on the basis of race, creed, color, national origin, gender, age, or disability.

Part-Time Employees
Beneficiary Designation

Employee Name: ________________________ SSN: ______________

TO THE PLAN ADMINISTRATOR:
I direct that, upon my death, any amount payable with respect to me under the above referenced plan, including the proceeds of any life insurance or annuity policies on my life purchased on my behalf pursuant to the terms of the plan, shall be paid to the following person (persons) as my primary beneficiary (beneficiaries):

Beneficiary Name		**Relationship**	**D.O.B.**
Address			
	City	State	Zip
Email Address		**Phone Number**	

Beneficiary Name		**Relationship**	**D.O.B.**
Address			
	City	State	Zip
Email Address		**Phone Number**	

If, upon my death, no primary beneficiary is living, such amount or amounts shall be paid to the following person (persons) as my contingent beneficiary (beneficiaries):

Beneficiary Name		**Relationship**	**D.O.B.**
Address			
	City	State	Zip
Email Address		**Phone Number**	

Beneficiary Name		**Relationship**	**D.O.B.**
Address			
	City	State	Zip
Email Address		**Phone Number**	

If I have designated more than one primary beneficiary, the said amount or amounts shall be equally divided among my primary beneficiaries who are living at the time of my death unless I have specified otherwise on this form. If, upon my death, there is no primary beneficiary living, and if I have named more than one contingent beneficiary, the said amount or amounts shall be equally divided among my contingent beneficiaries who are living at the time of my death unless I specify otherwise on this form.

The execution of this form and delivery thereof to the Plan administrator revokes all prior designations of beneficiaries that I may have made. This is an initial amended (check one) beneficiary designation.

PARTICIPANT SIGNATURE: ___________________________ DATE: ____________________
WITNESS SIGNATURE: _______________________________ DATE: ____________________
RECEIVED BY PLAN ADMINSTRATOR: _______________________