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