

**Carl Albert State College**

**Outstanding Wages Beneficiary Designation**

Carl Albert State College (CASC) offers its employees the option of designating a beneficiary to receive the employee’s final check in the event of an employee’s death while an employee of the college.

If you elect to name a beneficiary, you must complete the section below, Outstanding Wages Beneficiary Designation Form, at the time of your employment and submit to Human Resources along with all of your new hire paperwork. Should you desire to change your beneficiary at some point in the future, it will be your responsibility to complete and submit to Human Resources another Outstanding Wages Beneficiary Designation Form. For example, if you name your spouse and are later divorced, you may want to complete a new form.

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

**Contingent Beneficiary:** Receives distribution only if the primary beneficiary(s) are deceased at the time of the employee’s death.

*If an employee does not elect to name a beneficiary, the CASC 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 the conservators of their estates, will receive in equal shares a total up to the maximum of \$3,000 allowed by law. Any remaining payment would go into the estate and go through probate. Please be advised that access to the funds processed to an estate may be delayed due to the probate process.*

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**Carl Albert State College**

**Outstanding Wages Beneficiary Designation Form**

**Employee’s Name:** \_\_\_\_\_ **Employee ID:** \_\_\_\_\_

<b>Primary Beneficiary:</b>			
Full Name: _____		DOB: (mm/dd/yyyy): _____	
Social Security Number: _____		Relationship: _____	
Address: _____			
Street	City	State	Zip Code

**Please see reverse for additional beneficiaries and REQUIRED SIGNATURE.**

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**CONTINUATION PAGE**

<b>Beneficiary:</b> Primary: _____ <b>OR</b> Contingent: _____			
Full Name: _____		DOB: (mm/dd/yyyy): _____	
Social Security Number: _____		Relationship: _____	
Address: _____			
Street	City	State	Zip Code

<b>Beneficiary:</b> Primary: _____ <b>OR</b> Contingent: _____			
Full Name: _____		DOB: (mm/dd/yyyy): _____	
Social Security Number: _____		Relationship: _____	
Address: _____			
Street	City	State	Zip Code

<b>Beneficiary:</b> Primary: _____ <b>OR</b> Contingent: _____			
Full Name: _____		DOB: (mm/dd/yyyy): _____	
Social Security Number: _____		Relationship: _____	
Address: _____			
Street	City	State	Zip Code

<b>Beneficiary:</b> Primary: _____ <b>OR</b> Contingent: _____			
Full Name: _____		DOB: (mm/dd/yyyy): _____	
Social Security Number: _____		Relationship: _____	
Address: _____			
Street	City	State	Zip Code

\_\_\_\_\_  
PRINT EMPLOYEE FULL NAME

\_\_\_\_\_  
SIGNATURE OF EMPLOYEE

\_\_\_\_\_  
DATE

Return original form to agency Human Resources personnel and retain a copy for your records.  
Please keep all beneficiary information current.