



Important: The beneficiaries named on this form will replace any existing beneficiary information listed on your account. You must specify ALL Primary and Contingent Beneficiaries on this form even if you are changing only one beneficiary.

1 General information

Please type or print clearly.

First name of participant MI Last Smith

Address 123 Main St City Los Angeles State CA ZIP 90057

Email address* Daytime phone

Check here if the mailing address listed above is new. Our records will be updated accordingly.

Marital status: I am married. I am not married.

The beneficiary designation below only applies to the following account(s):

Name of organization Daytime phone Ext.

*Your privacy is important to us. For information on our privacy policies, visit www.capitalgroup.com.

2 Beneficiary designation

We encourage you to consult a professional regarding the tax-law and estate planning implications of your beneficiary designation. All stated percentages must be whole percentages (e.g., 33%, not 33.3%). If the percentages do not add up to 100%, each beneficiary's share will be based proportionately on the stated percentages. When a percentage is not indicated, the beneficiaries' shares will be divided equally.

- Notes: Your spouse may need to sign in Section 3. If you wish to name more than one trust or entity, customize your designation or need more space, attach a separate page. Include the name, address, relationship, date of birth or trust, SSN/TIN and percentage for each beneficiary. If you name a trust as beneficiary, provide the full legal name of the trust. Example: "The Davis Family Trust."

A. Primary Beneficiary(ies): If any designated Primary Beneficiary(ies) dies before I do, that beneficiary's share will be divided proportionately among the surviving Primary Beneficiaries unless otherwise indicated. If no Primary Beneficiaries survive me, assets will be paid to the named Contingent Beneficiaries, if any.

1. First name (print) MI Last name Luna Suffix

OR Name of trust or other entity (print)

Address City State ZIP

Spouse Child of owner Other person Trust Other entity Date of birth or trust (mm/dd/yyyy) SSN/TIN Whole % only %



2 Beneficiary designation (continued)

2. First name (print) MI Last name Suffix

Address City State ZIP

Spouse Child of owner Other person Date of birth (mm/dd/yyyy) SSN Whole % only

3. First name (print) MI Last name Suffix

Address City State ZIP

Spouse Child of owner Other person Date of birth (mm/dd/yyyy) SSN Whole % only

Important: Section 2-A must be completed prior to completing Section 2-B.

B. Contingent Beneficiary(ies): If no Primary Beneficiary survives me, pay my benefits to the following Contingent Beneficiary(ies). If any designated Contingent Beneficiary(ies) dies before I do, that beneficiary's share will be divided proportionately among the surviving Contingent Beneficiaries unless otherwise indicated. If no Contingent Beneficiaries survive me, assets will be paid according to the Custodial Agreement default designation.

1. First name (print) MI Last name Suffix

OR Name of trust or other entity (print)

Address City State ZIP

Spouse Child of owner Other person Trust Other entity Date of birth or trust (mm/dd/yyyy) SSN/TIN Whole % only

2. First name (print) MI Last name Suffix

Address City State ZIP

Spouse Child of owner Other person Date of birth (mm/dd/yyyy) SSN Whole % only

3. First name (print) MI Last name Suffix

Address City State ZIP

Spouse Child of owner Other person Date of birth (mm/dd/yyyy) SSN Whole % only



3 Spousal consent

Please consult your financial professional and/or employer about the need for spousal consent.

I am the spouse of the participant named in Section 1. I irrevocably consent to the designation made by my spouse to have any death benefits paid to the named beneficiary(ies) specified in Section 2. I understand that the effect of such designation is to cause my spouse's death benefit to be paid to a beneficiary other than me, that such beneficiary designation is not valid unless I consent to it and that my consent is irrevocable unless my spouse revokes the beneficiary designation.

This document may not be signed using Adobe Acrobat Reader's "fill and sign" feature.

Name of spouse of participant (print) Signature of spouse of participant Date (mm/dd/yyyy)

Note: If the employer sponsors an ERISA plan, the spousal consent must be witnessed or notarized. Please check with the Plan Sponsor if you need more information regarding the ERISA status of the plan.

Witnessed by: Plan representative Notary public

Signature of witness Date (mm/dd/yyyy)

NOTARY: Affix seal here.

4 Signature

By signing below, I acknowledge that I have completed this beneficiary designation form.

Signature of participant Date (mm/dd/yyyy)

This document may not be signed using Adobe Acrobat Reader's "fill and sign" feature.

If witnessed by a notary public, original signatures are required and this form must be mailed. Otherwise, you may fax this form to (888) 421-4371.

Please mail or fax this form to the appropriate service center. (If you live outside the U.S., mail the form to the Indiana Service Center.)



Indiana Service Center American Funds Service Company P.O. Box 6164 Indianapolis, IN 46206-6164 Overnight mail address 12711 N. Meridian St. Carmel, IN 46032-9181 Fax (888)-421-4371



Virginia Service Center American Funds Service Company P.O. Box 2560 Norfolk, VA 23501-2560 Overnight mail address 5300 Robin Hood Rd. Norfolk, VA 23513-2430 Fax (888)-421-4371

If you have questions or require more information, contact your financial professional or call American Funds Service Company at (800) 421-4225.