

PRE-COMMENCEMENT SURVIVOR BENEFIT DESIGNATION

ELIGIBLE EMPLOYEES PARTICIPATING IN THE FIRSTENERGY CASH BALANCE PLAN

FORM NO. X-4328 (REV. 08-14) Page 1 of 2

This form is to be used by Cash Balance Plan participants who want to designate at least one individual, and/or a trust, to be their pension Beneficiary in the event they die after becoming vested but before actually commencing their pension. If this form is not completed, the deceased participant's vested Cash Balance account will be distributed as follows:

- 1) all to their spouse at the time of death; or, if there is no spouse,
- 2) all to their surviving child or children (divided equally); or, if there are no children,
- 3) all to the executors or administrators of the deceased participant's estate

EMPLOYEE INFORMATION (Please Print)

EMPLOYEE NAME (First, Middle Initial, Last)		
SOCIAL SECURITY NO.	SAP NO.	DATE OF HIRE
DATE OF BIRTH	MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	EMPLOYEE GROUP (Check One) <input type="checkbox"/> NON-UNION <input type="checkbox"/> UNION - LOCAL _____

I understand that in order for the beneficiary(ies) designated on this form to receive any survivor benefit from my Cash Balance account, I must, at the time of my death:

- a) be vested (have 3 or more years of vesting service); and
 - b) have an account balance; and
 - c) be either unmarried or married and have designated a beneficiary other than or in addition to my spouse.
- IMPORTANT:** Married participant who designate a beneficiary other than or in addition to their spouse must have the spousal consent portion of this form completed.

I further understand that regardless of my designation, court ordered restrictions such as Qualified Domestic Relations Orders (QDROs) or Domestic Relations Orders (DROs) will be considered and may affect the Cash Balance amount available for distribution.

EMPLOYEE'S SIGNATURE	DATE SIGNED
WITNESS BY (Other than Beneficiary)	DATE SIGNED

SPOUSAL CONSENT

I hereby consent to the beneficiary designation(s) on this form and acknowledge that I understand that the effect of such designation may cause all or a portion of the Cash Balance account that I am entitled to receive upon the death of my spouse to be paid to someone other than myself. I further understand that if I am not the only beneficiary I cannot elect to receive my portion as an annuity.

SPOUSE'S SIGNATURE	DATE SIGNED
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NOTARY PUBLIC/HUMAN RESOURCES REPRESENTATIVE

Sworn before me this date _____. In the State of _____ County of _____

Notary Public Signature	Date Commission Expires
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-- OR --

Human Resources Representatives Signature	Date Signed
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BENEFICIARY INFORMATION (Please Print)

I hereby designate the beneficiary (ies) listed below to receive any survivor benefits related to my vested Cash Balance account in the event I die before the date my pension benefit commences. I understand that my Cash Balance account will be distributed equally among those designated who are living at the time of my death. I further understand that I may change these designations at any time with, as appropriate, spousal consent.

PERSON

BENEFICIARY'S NAME (First, Middle Initial, Last)		RELATIONSHIP <input type="checkbox"/> SPOUSE <input type="checkbox"/> INDIVIDUAL (not spouse)	
STREET ADDRESS	CITY	STATE	ZIP CODE
DATE OF BIRTH	SOCIAL SECURITY		

PERSON

BENEFICIARY'S NAME (First, Middle Initial, Last)		RELATIONSHIP <input type="checkbox"/> SPOUSE <input type="checkbox"/> INDIVIDUAL (not spouse)	
STREET ADDRESS	CITY	STATE	ZIP CODE
DATE OF BIRTH	SOCIAL SECURITY		

PERSON

BENEFICIARY'S NAME (First, Middle Initial, Last)		RELATIONSHIP <input type="checkbox"/> SPOUSE <input type="checkbox"/> INDIVIDUAL (not spouse)	
STREET ADDRESS	CITY	STATE	ZIP CODE
DATE OF BIRTH	SOCIAL SECURITY		

PERSON

BENEFICIARY'S NAME (First, Middle Initial, Last)		RELATIONSHIP <input type="checkbox"/> SPOUSE <input type="checkbox"/> INDIVIDUAL (not spouse)	
STREET ADDRESS	CITY	STATE	ZIP CODE
DATE OF BIRTH	SOCIAL SECURITY		

NOTE: If you want to designate more than four (4) persons as beneficiaries, please use a copy of this sheet and check the box provided to indicate that there is additional information attached.

Additional Information Attached

TRUST*

TRUST NAME (line 1)	TRUST DATE		
TRUST NAME (line 2)	TAX ID		
TRUSTEE NAME			
STREET ADDRESS	CITY	STATE	ZIP CODE

*Please attach a copy of the Trust Document to this form.