LIFE INSURANCE BENEFICIARY FORM

Employee Name: ____ Employee ID#: ____________

Primary Beneficiary:

1. Name: ____ DOB: ___________________

   Address: _______________________________ City, State, Zip: _____________________

   Gender: ______ Social Security Number: ________________ Relationship: ___________

   Basic Life Insurance ☐ Percentage Designated: _______%

   Supplemental Life Insurance ☐ Percentage Designated: _______%

2. Name: ____ DOB: ___________________

   Address: _______________________________ City, State, Zip: _____________________

   Gender: ______ Social Security Number: ________________ Relationship: ___________

   Basic Life Insurance ☐ Percentage Designated: _______%

   Supplemental Life Insurance ☐ Percentage Designated: _______%

Secondary Beneficiary:

1. Name: ____ DOB: ___________________

   Address: _______________________________ City, State, Zip: _____________________

   Gender: ______ Social Security Number: ________________ Relationship: ___________

   Basic Life Insurance ☐ Percentage Designated: _______%

   Supplemental Life Insurance ☐ Percentage Designated: _______%

2. Name: ____ DOB: ___________________

   Address: _______________________________ City, State, Zip: _____________________

   Gender: ______ Social Security Number: ________________ Relationship: ___________

   Basic Life Insurance ☐ Percentage Designated: _______%

   Supplemental Life Insurance ☐ Percentage Designated: _______%

(Attach additional sheet if necessary.)

All Beneficiary Information is required. To add an agency/institution as a beneficiary, use the Corporate Tax ID number in place of a Social Security number.

____ _________________________

Employee Signature Date

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