



LIFE INSURANCE BENEFICIARY CHANGE FORM

Employee Name: _____ DOB: _____

SS#: _____ Department/Agency: _____

Primary Beneficiary:

1. Name: _____ DOB: _____

Address: _____ GENDER: _____

_____ RELATIONSHIP: _____

Social Security Number: _____

Basic Life Insurance Percentage Designated: _____

Supplemental Life Insurance Percentage Designated: _____

2. Name: _____ DOB: _____

Address: _____ GENDER: _____

_____ RELATIONSHIP: _____

Social Security Number: _____

Basic Life Insurance Percentage Designated: _____

Supplemental Life Insurance Percentage Designated: _____

Secondary Beneficiary:

1. Name: _____ DOB: _____

Address: _____ GENDER: _____

_____ RELATIONSHIP: _____

Social Security Number: _____

Basic Life Insurance Percentage Designated: _____

Supplemental Life Insurance Percentage Designated: _____

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