

**CHANGE OF BENEFICIARY DESIGNATION**

*Please attach to original enrollment form*

**POLICY #** \_\_\_\_\_

**EMPLOYER/POLIC HOLDER NAME:** \_\_\_\_\_

**EMPLOYEE INFORMATION:**

**NAME** \_\_\_\_\_ **PHONE NUMBER** \_\_\_\_\_

**STREET ADDRESS** \_\_\_\_\_ **CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP CODE** \_\_\_\_\_

**PRIMARY BENEFICIARY(IES):**

**NAME** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

**RELATIONSHIP** \_\_\_\_\_ **BENEFIT PERCENT** \_\_\_\_\_

**NAME** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

**RELATIONSHIP** \_\_\_\_\_ **BENEFIT PERCENT** \_\_\_\_\_

**CONTINGENT BENEFICIARY(IES):**

**NAME** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

**RELATIONSHIP** \_\_\_\_\_ **BENEFIT PERCENT** \_\_\_\_\_

**NAME** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

**RELATIONSHIP** \_\_\_\_\_ **BENEFIT PERCENT** \_\_\_\_\_

**Definitions:**

**Primary Beneficiary:** The person or persons you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

**Contingent Beneficiary:** The person or persons you want to receive the life insurance benefit if you die and if no primary beneficiary is alive on that date. If more than one contingent beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

**I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).**

\_\_\_\_\_  
**EMPLOYEE SIGNATURE**

\_\_\_\_\_  
**DATE SIGNED**