

BENEFICIARY DESIGNATION FORM

Employer: _____

Policy Number: _____ Group ID#: _____

State: _____ Insured's Name: _____

Certificate Number: _____

BENEFICIARY DESIGNATION
Primary Designation: _____
Address: _____
Relationship to Insured: _____
SSN: _____
Contingent Beneficiary: _____
Address: _____
Relationship to Insured: _____
SSN: _____

Note: Contingent Beneficiary will receive benefits only if Primary Beneficiary does not survive you. If more than one Primary or Contingent Beneficiary is wanted, please attach a separate sheet to reflect this.

Insured's Signature: _____ Date Signed: _____