LIFE INSURANCE FORM

Employee Last Name _____ First Name _____ M.I. _____

SSN #_____ Date of Birth_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex: ☐ Male ☐ Female

Designation of Primary Beneficiary

Last Name _____ First Name _____ M. I. _____ Date of Birth _____ Relationship to Emp. _____

Street Address or PO Box _____ City _____ State / Zip _____

If the Beneficiary dies before me, I designate as contingent beneficiary:

Last Name _____ First Name _____ M. I. _____ Date of Birth _____ Relationship to Emp. _____

Street Address or PO Box _____ City _____ State / Zip _____

Last Name _____ First Name _____ M. I. _____ Date of Birth _____ Relationship to Emp. _____

Street Address or PO Box _____ City _____ State / Zip _____

Last Name _____ First Name _____ M. I. _____ Date of Birth _____ Relationship to Emp. _____

Street Address or PO Box _____ City _____ State / Zip _____

- If there is more than one primary beneficiary or more than one contingent beneficiary, they will share the death benefits equally, or all will be paid to the survivor.
- I RESERVE the right to change this designation at any time.

Employee Signature_____Date:_____