



**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: \_\_\_\_\_