



Former Elected Official Life Insurance Beneficiary Designation

Employee Name: _____ Employee ID#: _____
 Email Address: _____ Last 4 of SS#: _____

Basic and Supplemental Group Life Insurance and Accidental Death and Dismemberment (AD&D)
 When designating a trust as a beneficiary, it is necessary to attach a copy of the Trust Document to this form.

PRIMARY BENEFICIARY(IES)				
Name	Relationship	Phone Number	Address - (Home/ Apt#, City, State, Zip)	Percentage (must =100%)
			Street: _____	
			City, State, Zip: _____	
			Street: _____	
			City, State, Zip: _____	
			Street: _____	
			City, State, Zip: _____	
			Street: _____	
			City, State, Zip: _____	

CONTINGENT BENEFICIARY(IES): Will only be entitled to receive the death benefit if there are no surviving primary beneficiaries.

Name	Relationship	Phone Number	Address - (Home/ Apt#, City, State, Zip)	Percentage (must =100%)
			Street: _____	
			City, State, Zip: _____	
			Street: _____	
			City, State, Zip: _____	
			Street: _____	
			City, State, Zip: _____	

Please DO NOT sign until you are in the presence of Benefits Division Staff

Notarization is required if this form is mailed to the Benefits Division Office

Employee Signature with a copy of picture ID _____ Date Signed _____ Notary Stamp, Signature and Date _____

Benefits Division Staff Signature _____ Date Signed _____