



# PART TIME EMPLOYEE BENEFICIARY DESIGNATION

Employee Name: \_\_\_\_\_

Employee ID: \_\_\_\_\_ Last 4 digits of SS#: \_\_\_\_\_

## Basic and Supplemental Group Life Insurance

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%)

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%)

**Please DO NOT sign until you are in the presence of Employee Benefits Personnel**

\_\_\_\_\_  
Employee Signature with a copy of picture ID

\_\_\_\_\_  
Employee Benefits Personnel Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Date Received

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

\_\_\_\_\_  
Notary Signature and Date Stamp