Change of Beneficiary Designation

Member SSN [ ][ ][ ][ ][ ][ ][ ][ ][ ]

Member Information

Last Name

First Name   **Middle Initial**

Beneficiary Information

Last Name   **Gender**   ○ Male   ○ Female

First Name   **Middle Initial**

Date of Birth   [ ] / [ ] / [ ]   **SSN**

Mailing Address

City, State & Zip

Primary Phone   [ ] - [ ] - [ ]

Relationship

Designate a Beneficiary of Member's Life Insurance   ○ Primary   ○ Secondary   [ ] **% of Benefit**

Protected Health Information (PHI) Release Authorization

Do you authorize the Plan Administrative Office to speak with this person on your behalf, and about you and your coverage through this health plan?   ○ Yes   ○ No

Please select the type of information we can release to this beneficiary: ○ Health Plan Information   ○ Premium Information   ○ Authorization Information   ○ Claims Information

Beneficiary Information

Last Name   **Gender**   ○ Male   ○ Female

First Name   **Middle Initial**

Date of Birth   [ ] / [ ] / [ ]   **SSN**

Mailing Address

City, State & Zip

Primary Phone   [ ] - [ ] - [ ]

Relationship

Designate a Beneficiary of Member's Life Insurance   ○ Primary   ○ Secondary   [ ] **% of Benefit**

Protected Health Information (PHI) Release Authorization

Do you authorize the Plan Administrative Office to speak with this person on your behalf, and about you and your coverage through this health plan?   ○ Yes   ○ No

Please select the type of information we can release to this beneficiary: ○ Health Plan Information   ○ Premium Information   ○ Authorization Information   ○ Claims Information

Member's Authorization of this Change in Beneficiary Designation

I authorize the Plan Administrators office to effect a change in my life policy beneficiary designation, with the understanding that this will be accepted unless knowledge of court orders preventing such a change become known to the Plan Administration Office. I furthermore acknowledge that I am not subject to any coercive or mercenary influences while making this requested change.

_____   _____
Employee Signature   **Date**

This Section for Entity Benefit Coordinator Use Only

Entity Name

Effective Date   [ ] / [ ] / [ ]

SEND THE ORIGINAL OF THIS PAGE TO THE PLAN ADMINISTRATOR IMMEDIATELY