

Life Insurance Beneficiary Change Form

Employee Name: _____

Department/Agency: _____

SS#: _____

DOB (MM/DD/YYYY): _____

Basic Life Insurance:

Primary Beneficiary: _____

Relationship: _____

Secondary Beneficiary: _____

Relationship: _____

Signature: _____ Date: _____

Supplemental Life Insurance (existing policies):

(Please do not complete if you do not have a supplemental policy)

Primary Beneficiary: _____

Relationship: _____

Secondary Beneficiary: _____

Relationship: _____

Signature: _____ Date: _____

Please submit completed forms to the address above ATTN: C. Martinez - HR