

Beneficiary Designation Form

Employee Information (please print):

Last Name	First Name	Middle Initial	Social Security Number
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Date of Birth	Trinity Health Member Organization
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Beneficiary Designation:

I designate the following beneficiaries (show full name and relationship to insured) for my Basic and Employee Supplemental (if applicable) Group Life Insurance. I understand this will cancel any previous designations. If you elect more than one beneficiary, include the percentage each person should receive (total of all allocations must equal 100%).

Primary Beneficiaries (please print):

Name: (List below)	Relationship	Date of Birth	Percentage	
				%
				%
				%
				%
				%
				%
Total Primary Beneficiary Designation not to exceed 100%		Total %		%

Contingent Beneficiaries (please print):

Name: (List below)	Relationship	Date of Birth	Percentage	
				%
				%
				%
				%
				%
				%
Total Contingent Beneficiary Designation not to exceed 100%		Total %		%

Authorization:

Employee Signature	Date
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Please make a copy for your records and future reference.