Seattle Housing Authority
Group Term Life Insurance
Beneficiary Change Form

Last Name (Please Print) First Name | Employee No | Department

Home Address - Street | City, State | Zip

Hire Date | Work Phone | Birth Date | Social Security Number

GROUP TERM LIFE INSURANCE BENEFICIARY INFORMATION

Effective date of beneficiary change _____

List the beneficiary(ies) for *your* Basic and Supplemental Group Term Life Insurance. (You are the designated beneficiary for any spouse or partner, or dependent child loss.) Please specify the *percentage of benefit* for each beneficiary and if any beneficiary is *contingent*. *Contingent* means the person listed only receives the benefit if your named beneficiary is deceased. You are not required to list a contingent beneficiary. If more space is required, use a separate list, sign, date and attach to this form.

Beneficiaries for the Basic Group Term Life

Last Name (Please Print) First Name | Address | % of Benefit | ☐ Check if Contingent

Last Name First Name | Address | % of Benefit | ☐ Check if Contingent

Last Name (Please Print) First Name | Address | % of Benefit | ☐ Check if Contingent

Beneficiaries for the Supplemental Group Term Life

Last Name (Please Print) First Name | Address | % of Benefit | ☐ Check if Contingent

Last Name First Name | Address | % of Benefit | ☐ Check if Contingent

Last Name (Please Print) First Name | Address | % of Benefit | ☐ Check if Contingent

By signing below, I declare that the information on this form is true, correct and complete to the best of my knowledge, that I have read and understand descriptive material covering the options provided under this plan. I authorize the insurance carrier to obtain, examine or release information needed to process claims for myself or my family.

Employee's Signature _____ Date_____

Deliver to: Seattle Housing Authority Benefit Administrator

Revised October 2020