

SEATTLE HOUSING AUTHORITY

Accidental Death & Dismemberment (AD&D)

Beneficiary Change Form

Please Print Clearly

Last Name (Please Print)	First Name	Employee Number	
Home Address - Street	City	State	Zip
Hire Date	Birth Date (M/D/Y)	Social Security Number	

Effective date of beneficiary change: _____

BENEFICIARY: 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, please use a separate list, sign, date, and attach to form.

PLEASE PRINT

Last Name	First Name	Address	_____ % of Benefit <input type="checkbox"/> Check if Contingent
Last Name	First Name	Address	_____ % of Benefit <input type="checkbox"/> Check if Contingent
Last Name	First Name	Address	_____ % of Benefit <input type="checkbox"/> Check if Contingent
Last Name	First Name	Address	_____ % of Benefit <input type="checkbox"/> Check if Contingent
Last Name	First Name	Address	_____ % of Benefit <input type="checkbox"/> Check if Contingent
Last Name	First Name	Address	_____ % of Benefit <input type="checkbox"/> 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 the election form and 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 Signature** _____ **Date** _____