

# BENEFICIARY DESIGNATION FORM

**POLICY #:** 01-016868-00
**EMPLOYER/POLICYHOLDER NAME:** TUSCALOOSA PLUMBERS & STEAMFITTERS LOCAL 372
**EMPLOYEE INFORMATION:** [PLEASE PRINT ALL INFORMATION]

NAME	DATE OF BIRTH	PHONE NUMBER
MAILING ADDRESS	CITY	STATE ZIP CODE

<b>PRIMARY BENEFICIARY(IES):</b>	
NAME:	DATE OF BIRTH:
ADDRESS:	
RELATIONSHIP TO EMPLOYEE:	BENEFIT PERCENT:
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NAME:	DATE OF BIRTH:
ADDRESS:	
RELATIONSHIP TO EMPLOYEE:	BENEFIT PERCENT:
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<b>CONTINGENT BENEFICIARY(IES):</b>	
NAME:	DATE OF BIRTH:
ADDRESS:	
RELATIONSHIP TO EMPLOYEE:	BENEFIT PERCENT:
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NAME:	DATE OF BIRTH:
ADDRESS:	
RELATIONSHIP TO EMPLOYEE:	BENEFIT PERCENT:

**DEFINITIONS**

**Primary Beneficiary:** The person or persons you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

**Contingent Beneficiary:** The person or persons you want to receive the life insurance benefit if you die and if no primary beneficiary is alive on that date. If more than one contingent beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

**I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).**

**EMPLOYEE SIGNATURE**
**DATE SIGNED**