Print Form

BENEFICIARY DESIGNATION/CHANGE

In order to process your request, this form must be dated, witnessed and signed in ink. Please keep a copy for your records.

Group # **Division** **Class** **Certificate #**

Name of Employee (Surname, first name, middle initial)

Name of Employer

I revoke all prior beneficiary designations under this certificate. I hereby designate the following person(s) to receive all group life insurance benefits payable on my death. If more than 1 person is named, proceeds are to be shared equally, unless otherwise indicated below.

PRIMARY BENEFICIARY(IES)

Name(s) (First, Middle Initial, Last)	**Relationship to Employee**	**Share** (must = 100%)
		%
		%
		%

CONTINGENT BENEFICIARY(IES)

If a primary beneficiary dies before the Employee, that beneficiary's share will be paid to the Estate of the Employee unless otherwise clearly indicated.

Name(s) (First, Middle Initial, Last)	**Relationship to Employee**	**Share** (must = 100%)
		%
		%
		%

TRUSTEE - If beneficiary is under age 18

Consider naming a Trustee as benefits cannot be paid to a minor. Benefits will be paid to the named Trustee (regardless of beneficiary age) unless you change the designation to remove the Trustee.

Name (First, Middle Initial, Last)	**As Trustee for** (Beneficiary Name)	**Relationship to Beneficiary**

AUTHORIZATION:

I understand the information I provide on this form will be used by RWAM Insurance Administrators Inc.(RWAM) and the insurer to administer benefits under this coverage. This designation will remain in effect until revoked in writing by the employee.

Employee Signature (in ink) X_____ **Date** _____

Witness must be over 18 & not be a beneficiary

Witness Signature (in ink) X_____ **Date** _____