



BENEFICIARY CHANGE AUTHORIZATION

DESIGNATION OF BENEFICIARY: *Please print*

NAME (LAST, FIRST, MIDDLE INITIAL) _____ GROUP NUMBER _____

EMPLOYEE SOCIAL SECURITY NUMBER _____

CHECK ALL THAT APPLY:

- 5,000 or 7,500 Basic Life and AD&D (Administered by SET SEG)
- Voluntary Group Term Life
Policy Number _____
- Employer sponsored Group Life & AD&D
Policy Number _____
- Other _____
Policy Number _____

PRIMARY BENEFICIARY: *Please print*

Subject to the terms of my Group Insurance Policy, I hereby amend and revoke any former beneficiary(ies) named by me and designate the following as my beneficiary(ies):

FULL NAME AND ADDRESS	PERCENTAGE* (MUST TOTAL 100%)	DATE OF BIRTH	RELATIONSHIP	SOCIAL SECURITY NUMBER

** If no percentages are indicated, benefits will be divided equally between all primary beneficiaries.*

CONTINGENT BENEFICIARY(IES) Applicable only if you are not survived by one or more primary beneficiary: *Please print*

FULL NAME AND ADDRESS	PERCENTAGE* (MUST TOTAL 100%)	DATE OF BIRTH	RELATIONSHIP	SOCIAL SECURITY NUMBER

** If no percentages are indicated, benefits will be divided equally between all primary beneficiaries.*

SIGNATURE:

- Unless indicated otherwise, if any beneficiary predeceases you, that beneficiary's share will be divided pro-rata among the surviving beneficiaries of the same class (primary and contingent).
- If no beneficiary (primary or contingent) survives you, payment will be made pursuant to the terms of the applicable policy.

EMPLOYEE SIGNATURE _____

DATE _____

SUBMIT COMPLETED FORM TO:

Upload to: www.setseg.org
Choose "Upload Employee Enrollment Forms" from the Employee Benefit Services menu

Email To: enrollment@setseg.org