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
☐ Check if Contingent

DOB Relationship

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

DOB Relationship

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

DOB Relationship

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

DOB Relationship

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**__________________