SEATTLE HOUSING AUTHORITY

Group Term Life Insurance 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 _____

List the beneficiary(ies) for *your* Basic and Supplemental Group Term Life Insurance. (You are the designated beneficiary for any spouse or partner, or dependent child loss.) Please 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, use a separate list, sign, date and attach to this form.

Beneficiaries for Basic Group Term Life

Last Name (Please Print) First Name _____ Address _____ _____% of Benefit ❑ Check if Contingent

Last Name (Please Print) First Name _____ Address _____ _____% of Benefit ❑ Check if Contingent

Last Name (Please Print) First Name _____ Address _____ _____% of Benefit ❑ Check if Contingent

Last Name (Please Print) First Name _____ Address _____ _____% of Benefit ❑ Check if Contingent

Last Name (Please Print) First Name _____ Address _____ _____% of Benefit ❑ Check if Contingent

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Beneficiaries for Supplemental Group Term Life

Last Name (Please Print) First Name _____ Address _____ _____% of Benefit ❑ Check if Contingent

Last Name (Please Print) First Name _____ Address _____ _____% of Benefit ❑ Check if Contingent

Last Name (Please Print) First Name _____ Address _____ _____% of Benefit ❑ Check if Contingent

Last Name (Please Print) First Name _____ Address _____ _____% of Benefit ❑ Check if Contingent

Last Name (Please Print) First Name _____ Address _____ _____% of Benefit ❑ Check if Contingent

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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** _____