

County Provided Basic Life Insurance DESIGNATION OF BENEFICIARY FORM

Note to Human Resources: Please retain a copy of this form in your personnel files; it does not need to be sent to Guardian unless or until a claim is filed.

Group Name: **County of Summit / Guardian**
 Group Number: **00576937**

Employee Last Name: First Middle Initial

Employee Social Security Number:

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Employee Birth Date: / /
Mo. *Day* *Year*

Male Female (circle one) Single Married (circle one)

Primary Beneficiary *Address* *Relationship to you* %

Primary Beneficiary *Address* *Relationship to you* %

Primary Beneficiary *Address* *Relationship to you* %

Secondary Beneficiary *Address* *Relationship to you* %

Secondary Beneficiary *Address* *Relationship to you* %

Secondary Beneficiary *Address* *Relationship to you* %

Tertiary Beneficiary *Address* *Relationship to you* %

Tertiary Beneficiary *Address* *Relationship to you* %

Signature of the Insured

Date