DESIGNATION OF BENEFICIARY FOR CONTRA COSTA COUNTY GROUP LIFE INSURANCE PLANS

Instructions: Type or print in ink. Return completed form to Contra Costa County, Department of Human Resources, Employee Benefits Services Unit, 651 Pine Street, Martinez, CA, 94553

Employee Name		
Employee Number	Social Security Number	Date of Birth

I request that the beneficiary for the following policy(ies) be designated as indicated below: (check appropriate boxes)

☐ **County Paid Basic Life Insurance**	☐ **Management Life Insurance**	☐ **Supplemental Life Insurance**

Unless otherwise provided in this request, if two or more primary beneficiaries are named, the proceeds shall be paid in equal shares to the named primary beneficiaries if surviving the insured, or to the survivor or survivors. If no primary beneficiaries survive, the proceeds shall be paid in equal shares to the named contingent beneficiaries, if any. If no beneficiary survives, payment shall be made according to the terms of the policy. The right of the insured to change the beneficiary hereafter is reserved .

Primary Beneficiaries: If more than 4 beneficiaries are designated, please attach a second designation form.

Name (1)	Address	Percent of Benefit *(must add up to 100%)*
Date of Birth	Social Security Number	Relationship
Name (2)	Address	Percent of Benefit *(must add up to 100%)*
Date of Birth	Social Security Number	Relationship
Name (3)	Address	Percent of Benefit *(must add up to 100%)*
Date of Birth	Social Security Number	Relationship
Name (4)	Address	Percent of Benefit *(must add up to 100%)*
Date of Birth	Social Security Number	Relationship

Contingent Beneficiaries: If more than 4 beneficiaries are designated, please attach a second designation form.

Name (1)	Address	Percent of Benefit *(must add up to 100%)*
Date of Birth	Social Security Number	Relationship
Name (2)	Address	Percent of Benefit *(must add up to 100%)*
Date of Birth	Social Security Number	Relationship
Name (3)	Address	Percent of Benefit *(must add up to 100%)*
Date of Birth	Social Security Number	Relationship
Name (4)	Address	Percent of Benefit *(must add up to 100%)*
Date of Birth	Social Security Number	Relationship

This designation is revocable as to each beneficiary except when otherwise stated, and beneficiaries of like class shall share equally with right of survivorship. The insurance company will not accept any designation using the words "Per Stirpes." Please refer to the Suggested Beneficiary Designations on the reverse side of this form. Any designation of an individual shall mean an individual living at the insured's death.

Dated this day of , 20 , at (city) (state)

Employee Signature	Signature of Irrevocable Beneficiary(ies), if any

EMPLOYEE BENEFITS SERVICES UNIT USE ONLY

Date Received	Date HRIS Processed	Processed by