Life Insurance Beneficiary Designation Form

Standard Insurance Company Policy # 642496-B
EMPLOYER/POLICY HOLDER NAME: The Regents of the University of Colorado SOM Graduate Medical Education
EMPLOYEE INFORMATION (Please write above line)

LAST NAME FIRST NAME PHONE NUMBER

STREET ADDRESS CITY STATE ZIP CODE

PRIMARY BENEFICIARY(IES)

LAST NAME FIRST NAME / / DATE OF BIRTH (MM/DD/YYYY)

ADDRESS (STREET ADDRESS, CITY, STATE, ZIP)

RELATIONSHIP PERCENTAGE OF BENEFIT ALLOTTED TO THIS BENEFICIARY

LAST NAME FIRST NAME / / DATE OF BIRTH (MM/DD/YYYY)

ADDRESS (STREET ADDRESS, CITY, STATE, ZIP)

RELATIONSHIP PERCENTAGE OF BENEFIT ALLOTTED TO THIS BENEFICIARY

CONTINGENT BENEFICIARY(IES)

LAST NAME FIRST NAME / / DATE OF BIRTH (MM/DD/YYYY)

ADDRESS (STREET ADDRESS, CITY, STATE, ZIP)

RELATIONSHIP PERCENTAGE OF BENEFIT ALLOTTED TO THIS BENEFICIARY

LAST NAME FIRST NAME / / DATE OF BIRTH (MM/DD/YYYY)

ADDRESS (STREET ADDRESS, CITY, STATE, ZIP)

RELATIONSHIP PERCENTAGE OF BENEFIT ALLOTTED TO THIS BENEFICIARY

DEFINITIONS

Primary Beneficiary: The person or persons you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

Contingent Beneficiary: The person or persons you want to receive the life insurance benefit if you die and if no primary beneficiary is still alive on that date. If more than one contingent beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

☐ **REQUIRED AUTHORIZATION**

By checking this box, I understand I reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies) and confirm this as my beneficiary designation as of this date: _____

DATE