RETIREE LIFE INSURANCE POLICY (BEN-F033) - $7,000
Certified Employees (20 years of service required)

Please print clearly. A copy of this form is maintained in the CMCSS Benefits Office.

YOUR NAME _____
(LAST) (FIRST) (M.I)

HOME ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

SOCIAL SECURITY NUMBER _____

DATE OF BIRTH _____ SEX ( ) MALE ( ) FEMALE

HOME PHONE _____

DESIGNATION OF BENEFICIARY

I Designate as my Primary Beneficiary:

NAME _____
(LAST) (FIRST) (M.I)

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

PHONE _____

DATE OF BIRTH _____ RELATIONSHIP TO EMPLOYEE _____

Additional Primary Beneficiary:

NAME _____
(LAST) (FIRST) (M.I)

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

PHONE _____

DATE OF BIRTH _____ RELATIONSHIP TO EMPLOYEE _____

If the above Primary Beneficiary/Beneficiaries die before me, I designate the following contingent beneficiary:

NAME _____
(LAST) (FIRST) (M.I)

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

PHONE _____

DATE OF BIRTH _____ RELATIONSHIP TO EMPLOYEE _____

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Additional Contingent Beneficiary:

NAME _____
(LAST) (FIRST) (M.I)

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

PHONE _____

DATE OF BIRTH _____ RELATIONSHIP TO EMPLOYEE _____

- If there is more than one primary beneficiary, or more than one contingent beneficiary, they will share the death benefits equally, or will be paid to the survivor.
- I reserve the right to change this designation at any time by contacting the CMCSS Benefits Office.

_____ _____
Signature Date