



# Life Insurance Beneficiary Designation Form

Employee Name: \_\_\_\_\_  SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(Please Print)

All benefit eligible employees, whether they elect to participate in other benefit programs provided by the Archdiocese, are automatically covered under the Group Life Insurance Plan at a benefit of 2.5 times their annual salary.

## Life Insurance Beneficiary Designation

Please note: If you are also electing the Voluntary Life Insurance Coverage, *the primary and secondary beneficiaries and their percentages must be identical on both forms.*

**Primary Beneficiary(ies)** - I hereby designate the following person(s) as my Primary Beneficiary(ies) under the Plan and revoke any beneficiary designation I may have previously made:

Name of Primary Beneficiary(ies)	Relationship	Percentage (Must Total 100%)
_____	_____	_____ %
_____	_____	_____ %
_____	_____	_____ %

**Secondary Beneficiary(ies)** - I hereby designate the following person(s) as my Secondary Beneficiary(ies) under the plan and revoke any beneficiary designation I may have previously made. *Secondary beneficiaries become entitled to payment ONLY IF ALL Primary Beneficiaries named above predecease the participant:*

Name of Secondary Beneficiary(ies)	Relationship	Percentage (Must Total 100%)
_____	_____	_____ %
_____	_____	_____ %
_____	_____	_____ %

X \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Employee Signature Date Daytime Phone Number