Instructions for completing the Beneficiary Designation Form

This beneficiary form applies to the HealthChoice Life Insurance Plan offered through the Employees Group Insurance Division. If you are retired, it does not affect the beneficiaries for any death benefit you may have through your retirement system.

The beneficiary designations you make on this form replace and cancel all prior life insurance beneficiary designations with EGID. **Your designations do not become effective until this form is signed and received by EGID.** Do not alter this form or attach additional pages.

It is very important that you provide the **full legal name, address, relationship, date of birth and Social Security number of each beneficiary you designate.** This information is essential in ensuring that your named beneficiaries can be located and receive your intended benefit amount. The Beneficiary Designation Form has four parts: Member Information, Primary Beneficiary(ies), Contingent Beneficiary(ies) and the Member signature. **If you complete the form by hand, please print clearly in ink.**

Member Information – Provide your name, SSN or Member ID and address.

Primary Beneficiary(ies) – You can designate one or more primary beneficiaries. All primary beneficiaries share equally unless you note otherwise. If multiple primary beneficiaries are named and a primary beneficiary dies before or simultaneously with you, the remaining primary beneficiary(ies) will be entitled to equal share of the deceased beneficiary's designated benefit amount.

Contingent Beneficiary(ies) – You can designate one or more contingent beneficiaries. Contingent beneficiaries receive benefits only in the event all primary beneficiaries die before or simultaneously with you. All contingent beneficiaries share equally unless you note otherwise on your form. If multiple contingent beneficiaries are named and a contingent beneficiary dies before or simultaneously with you, the remaining contingent beneficiary(ies) will be entitled to equal share of the deceased beneficiary's designated benefit amount.

Member signature – You must sign and date your form. **Your signature must be original in ink.**

Special beneficiary designations

Sometimes members wish to make a special designation for trusts, minors or institutions. If you wish to make a special designation, please read the following information carefully:

Designating a trust as beneficiary – To designate a trust as beneficiary, provide the actual name of the trust and the date the trust was created in the space provided.

Designating a minor as beneficiary – A minor can be named your beneficiary; however, it is often difficult and costly for a minor to receive payment, especially if the amount exceeds $10,000. Before you designate a minor as your beneficiary, you should consult an attorney or professional financial advisor.

Designating an institution as beneficiary – To designate an institution (church, charity, funeral home, etc.) as your beneficiary, provide the full name of the institution and list the address in the space provided.

After you complete and sign the Beneficiary Designation Form, mail it to:

Employees Group Insurance Division
P.O. Box 11137, Oklahoma City, OK 73136-9998

Remember to keep a copy of your completed form for your records.

OKLAHOMA
Employees Group Insurance Division

Employees Group Insurance Division
Beneficiary Designation Form

Member Information

SSN or Member ID: _____ Member name: _____
First MI Last

Address: _____
☐ New address Street City State ZIP

Phone: (____) _____ Alt Phone: (____) _____

Important: Please ensure the Share percentage in both Primary Beneficiary(ies) and Contingent Beneficiary(ies) add up to 100%. Payment will be made in equal shares to all surviving beneficiaries unless otherwise indicated.

Primary Beneficiary(ies)

Primary beneficiary's name and address	SSN	Phone	Relationship	Date of birth	Share percentage
					100%

Contingent Beneficiary(ies)

Proceeds are paid to the contingent beneficiary(ies) identified below only if there is no surviving primary beneficiary(ies).

Contingent beneficiary's name and address	SSN	Phone	Relationship	Date of birth	Share percentage
					100%

I have named the above beneficiary(ies) to receive my life insurance benefits from HealthChoice. I understand this form replaces and cancels all prior beneficiary designations and will become effective only when it is received by EGID.

_____ _____
Member signature (original signature required) Date

Mail this form to EGID at P.O. Box 11137, Oklahoma City, OK 73136-9998