Life Insurance Beneficiary Designation Form

Please complete the information below and return to Human Resources.
For assistance, please contact the Benefits Division at (361) 826-3300.

Employee Information			
NAME (Last, First, MI)	SSN	DOB	EMP ID
ADDRESS, CITY AND ZIP		PHONE	DEPT:

Please complete the information below and designate a primary/contingent beneficiary, if applicable.
You may continue to add beneficiaries to the back of this page if necessary

	Beneficiary Name	Relationship to Employee	SSN	Date of Birth	Primary or Contingent	Percentage (Needs to total 100% for Primary and 100% for Contingent)	Contact Information (Address, Phone # or email)
1							
2							
3							
4							

I acknowledge and understand the benefits information listed above is for the City of Corpus Christi Life insurance plans. **Beneficiary changes to my retirement plan must be submitted directly to the Texas Municipal Retirement System on their designated form.** I also have the right to change my beneficiary information at any time throughout the year.

Important Note For Married Employees: If you live in a community property state you should obtain the signature of your spouse if your spouse will not be named as primary beneficiary. Payments of benefits may be delayed or disputed unless your spouse consents to waive their rights to any community property interest in the benefits.

Spousal Consent: I hereby consent to the Primary Beneficiary designated by my spouse. This consent supersedes any prior spousal consent I may have given under this plan.

Spouse Signature _____ Date: _____

Signature: _____ Date: _____

☐ Employee has no legal spouse

Infor Entry Date: _____ Infor Entry Initials: _____