



Beneficiary Designation Form

Life Insurance
 Long-Term Disability
 Accident Insurance
 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 insurance plans identified at the top of this form. I also have the right to change my beneficiary information at any time throughout the year. **Beneficiary changes to my retirement plan must be submitted directly to the Texas Municipal Retirement System on their designated form. My ICMA_RC 457 retirement plan beneficiary designations must be completed online.**

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.

Marital Status:
 Married
 Single (Employee has no legal spouse)

Signature: _____ **Date:** _____



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Section: Spousal Consent

I consent to my spouse's waiver of joint and survivorship benefits with respect to death proceeds. I understand that this consent means that I will not receive any survivor benefits under this plan upon my spouse's death with respect to these listed plan(s). I understand that I do not have to consent to the waiver of this joint and survivor annuity coverage, however, if I do consent by signing below, I may not revoke my consent.

(Spouse Signature)

(Date)

WITNESSED:

(Plan Administrator Signature or Notary Public Signature)

(Date)