Beneficiary Designation Form

Life Insurance, Long-Term Disability, Accident Insurance

Please complete the form below and return to the Benefits Division, Human Resources. For assistance, please contact the Benefits Division at (361) 826-3300, option 2.

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 the page if necessary.

1 Name	SSN	DOB	Relationship
Address, City and Zip	Phone	Primary/Contingent	Percent (%)
2 Name	SSN	DOB	Relationship
Address, City and Zip	Phone	Primary/Contingent	Percent (%)
3 Name	SSN	DOB	Relationship
Address, City and Zip	Phone	Primary/Contingent	Percent (%)
4 Name	SSN	DOB	Relationship
Address, City and Zip	Phone	Primary/Contingent	Percent (%)
5 Name	SSN	DOB	Relationship
Address, City and Zip	Phone	Primary/Contingent	Percent (%)

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 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 Mission Square (formerly ICMA) retirement plan(s) 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 any rights to any community property interest in the benefits.

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

Signature: _____ **Date:** _____

For Benefits Use Only

Infor Entry Date: Infor Entry Initials:

Beneficiary Designation Form

Life Insurance, Long-Term Disability, Accident Insurance

Please complete the form below and return to the Benefits Division, Human Resources. For assistance, please contact the Benefits Division at (361) 826-3300, option 2.

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 or Notary Public Signature *Date*

For Benefits Use Only

Infor Entry Date: Infor Entry Initials: