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 and secondary beneficiary, if applicable.

Term Life Beneficiary Designation				
#1 BENEFICIARY NAME (Last, First, MI)	**GENDER (M/F)**	**SSN**	**DOB**	**MARITAL STATUS**
ADDRESS (IF OTHER THAN EMP)	PHONE ( )	***PRIMARY/SECONDARY***	PERCENT %	RELATIONSHIP
# 2 BENEFICIARY NAME (Last, First, MI)	**GENDER (M/F)**	**SSN**	**DOB**	**MARITAL STATUS**
ADDRESS (IF OTHER THAN EMP)	PHONE ( )	***PRIMARY/SECONDARY***	PERCENT %	RELATIONSHIP
# 3 BENEFICIARY NAME (Last, First, MI)	**GENDER (M/F)**	**SSN**	**DOB**	**MARITAL STATUS**
ADDRESS (IF OTHER THAN EMP)	PHONE ( )	***PRIMARY/SECONDARY***	PERCENT %	RELATIONSHIP

I acknowledge that I understand the benefits information listed above is for the City of Corpus Christi Life insurance plans. **Changes to your retirement plan must be submitted directly to the Texas Municipal Retirement System on their designation form.** I also understand that I have the right to change my beneficiary designation anytime throughout the year.

Signature: ____ Date: ____________________

Entry Date: ________________________ Entry Initials: _____________________