



Michigan Electrical Employees' Health Plan
6011 W. St. Joseph • Suite 401 • Lansing, MI 48917
517/323-9250 • 800/323-8943 (Michigan only)
www.meehp.com • FAX 517/323-1093



BENEFICIARY DESIGNATION FORM

MEMBER NAME: _____ **SOCIAL SECURITY #:** _____

The right is reserved to change the beneficiary hereby designated without the consent of said beneficiary(ies). If more than one Primary beneficiary is designated, settlement will be made in accordance with the designated percentage indicated above or equal shares to such Primary designated beneficiaries as survives the insured when designated amount is not disclosed. If no Primary designated beneficiary(ies) survives the insured, settlement will be made in accordance with the designation of Contingent beneficiary(ies) or in accordance with the terms of the above group's contract(s).

BENEFICIARY: NAME OF PERSON YOU WANT TO RECEIVE YOUR LIFE INSURANCE					
(If you name more than one, they will share equally unless you state otherwise or name one as contingent beneficiary)					
NAME (LAST)	(FIRST)	(INITIAL)	BIRTH DATE	SOC. SEC. #	RELATIONSHIP
STREET ADDRESS			CITY	STATE	ZIP PHONE #
NAME (LAST)	(FIRST)	(INITIAL)	BIRTH DATE	SOC. SEC. #	RELATIONSHIP
STREET ADDRESS			CITY	STATE	ZIP PHONE #
NAME (LAST)	(FIRST)	(INITIAL)	BIRTH DATE	SOC. SEC. #	RELATIONSHIP
STREET ADDRESS			CITY	STATE	ZIP PHONE #

I understand that, in the event of my death, the most recently signed and dated beneficiary card on file with the Plan Office will be used to determine the beneficiary(ies) who will receive my life insurance and accidental death and dismemberment insurance benefits.

I hereby certify that the foregoing statements are to the best of my knowledge and belief true, correct, and complete.

Signatures Required: This change will not be valid unless signatures and Dates below are filled out completely.

Signature of Insured

Signature of Witness

Date

Date