Medical College of Wisconsin Employee Benefit Plan
Group Life Insurance
Beneficiary Designation Form

Please type or print.   ***Be sure to sign and date at the bottom of this form***.

Insured's Name _____

Insured's Marital Status: ☐ Single   ☐ Married**   Insured's Social Security #_____

Spousal consent is required if your spouse is not listed as a Primary Beneficiary for at least 50%.**

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Primary Beneficiary(ies): (Please indicate the relationship and Social Security Number of each beneficiary.)

NAME (PLEASE PRINT):		RELATIONSHIP TO INSURED:
ADDRESS:	SS#, DATE, PHONE	PERCENTAGE OF PRIMARY TO TOTAL BENEFIT (OPTIONAL) %
NAME (PLEASE PRINT):		RELATIONSHIP TO INSURED:
ADDRESS:	SS#, DATE, PHONE	PERCENTAGE OF PRIMARY TO TOTAL BENEFIT (OPTIONAL) %
NAME (PLEASE PRINT):		RELATIONSHIP TO INSURED:
ADDRESS:	SS#, DATE, PHONE	PERCENTAGE OF PRIMARY TO TOTAL BENEFIT (OPTIONAL) %

Total percentages should add up to 100%. If no percentages are indicated, the proceeds will be divided equally. If a Primary beneficiary dies before the Insured, that beneficiary's portion will be distributed proportionately to the surviving Primary beneficiary(ies). If no Primary beneficiary survives, proceeds will be paid to the Contingent beneficiary(ies) listed below. Use the back of this form is you wish to name additional Primary or Contingent beneficiaries and make a notation to "see back".

Contingent Beneficiary(ies):

(Please indicate the relationship and Social Security Number of each beneficiary. This supersedes any prior designations.)

NAME (PLEASE PRINT):		RELATIONSHIP TO INSURED:
ADDRESS:	SS#, DATE, PHONE	PERCENTAGE OF PRIMARY TO TOTAL BENEFIT (OPTIONAL) %
NAME (PLEASE PRINT):		RELATIONSHIP TO INSURED:
ADDRESS:	SS#, DATE, PHONE	PERCENTAGE OF PRIMARY TO TOTAL BENEFIT (OPTIONAL) %

X_____   _____ / _____ / _____

INSURED'S SIGNATURE   DATE SIGNED

X_____   _____ / _____ / _____

**SPOUSE SIGNATURE   DATE SIGNED