Medical College of Wisconsin Affiliated Hospitals, Inc.
Group Life Insurance
Beneficiary Designation Form
Information

To submit a revised GROUP LIFE INSURANCE BENEFICIARY DESIGNATION FORM:

- **Complete the attached Group Life Insurance Beneficiary Designation Form**
- **Sign and date <u>with ink</u> and return to MCWAH. The form can be brought to the office in person or returned via USPS to:**

MCWAH\GME, 8701 Watertown Plank Rd, Milwaukee WI 53226.

If you already have a Group Life Beneficiary Designation Form on file, all prior designation forms will be superceeded by the most recently dated form received in the MCWAH\GME office.

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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%.***

Primary Beneficiary(ies): Person or persons who will receive the Life Insurance Proceeds upon your death.

NAME AND ADDRESS:		RELATIONSHIP TO INSURED:
DATE OF BIRTH	SOC. SEC. NUMBER	PERCENTAGE TO BE PAID TO THIS BENEFICIARY %
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DATE OF BIRTH	SOC. SEC. NUMBER	PERCENTAGE TO BE PAID TO THIS BENEFICIARY %
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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):

Person or persons who will receive the Life Insurance Proceeds if there is no surviving Primary Beneficiary.

NAME AND ADDRESS:		RELATIONSHIP TO INSURED:
DATE OF BIRTH	SOC. SEC. NUMBER	PERCENTAGE TO BE PAID TO THIS BENEFICIARY %
NAME AND ADDRESS:		RELATIONSHIP TO INSURED:
DATE OF BIRTH	SOC. SEC. NUMBER	PERCENTAGE TO BE PAID TO THIS BENEFICIARY %

X _____ ____/____/____

INSURED'S SIGNATURE DATE SIGNED

X _____ ____/____/____

**SPOUSE SIGNATURE DATE SIGNED