



BENEFICIARY DESIGNATION FORM

PLEASE RETURN THIS FORM TO THE EMPLOYEE BENEFITS OFFICE, CCK Building

Applicant Data

Name		Social Security #	
Address		Phone #	

Beneficiary Designation

Basic/Supplemental Life and Travel Accident Insurance

Please indicate the desired percentage for each beneficiary and for each benefit. If a percentage amount for each beneficiary is not indicated or if the percentages do not equal 100%, then the benefit for each product will be paid equally to each named beneficiary.

Beneficiary Name (First Name, M.I., Last Name)	Relationship	Date of birth	SS#	Address (No. Street, City, State, Zip Code)	Basic Life Percent	Supplemental Life Percent	Travel Accident Percent
Primary							
		/ /	- -				
		/ /	- -				
		/ /	- -				
		/ /	- -				
		/ /	- -				
		/ /	- -				

If any of the above named Primary Beneficiaries predeceases me, the proceeds will be payable equally to the remaining Primary Beneficiary(ies) for each product. The Contingent Beneficiary(ies) below will only receive proceeds if all Primary Beneficiary(ies) for each product predeceases me.

Contingent							
		/ /	- -				
		/ /	- -				
		/ /	- -				
		/ /	- -				

Authorization

I certify the above information to be correct and true to the best of my knowledge.

This beneficiary designation shall be subject to the applicable plan documents and summary plan descriptions. St. John's University fully intends to maintain these plans indefinitely. However, it reserves the right, subject to applicable collective bargaining agreements, to terminate, suspend, discontinue or amend the Plan(s) at any time and for any reason.

X _____
Employee Signature

Date