|  |
| --- |
| **[ ]**  NEW ENROLLMENT **[ ]**  REFUSAL **[ ]**  CHANGE **[ ]**  CANCELLATIONReason for Change:       |
| EMPLOYMENT DATE:       |
| **SUBSCRIBERS NAME (Last, First, MI)** | **SOCIAL SECURITY NUMBER** | **EMPLID** | BIRTHDATE |
| **,**  |        |       |       |
|  |
| I hereby designate the following as my beneficiaries under the group life insurance plan provided by the Missouri State Highway Commission; and reserve the right to change or revoke such designation at any time. |
| PRIMARY BENEFICIARY DESIGNATION |
| **NAME (1)** | **PHONE NUMBER** | SOCIAL SECURITY NUMBER | **RELATIONSHIP** | **PERCENT OF BENEFIT** |
|       |       |       |       |    % |
| HOME ADDRESS (1) | CITY | STATE | ZIP |
|       |       |       |       |
| NAME (2) | **PHONE NUMBER** | **SOCIAL SECURITY NUMBER** | **RELATIONSHIP** | **PERCENT OF BENEFIT** |
|       |       |       |       |    % |
| HOME ADDRESS (2) | CITY | STATE | ZIP |
|       |       |       |       |
| **NAME (3)** | **PHONE NUMBER** | SOCIAL SECURITY NUMBER | **RELATIONSHIP** | **PERCENT OF BENEFIT** |
|       |       |       |       |    % |
| HOME ADDRESS (3) | CITY | STATE | ZIP |
|       |       |       |       |
| **NAME (4)** | **PHONE NUMBER** | SOCIAL SECURITY NUMBER | **RELATIONSHIP** | **PERCENT OF BENEFIT** |
|       |       |       |       |    % |
| HOME ADDRESS (4) | CITY | STATE | ZIP |
|       |       |       |       |
| TOTAL FOR PRIMARY BENEFICIARY (MUST BE 100%) | TOTAL |
|  |    % |
| CONTINGENT BENEFICIARY DESIGNATION |
| **NAME (1)** | **PHONE NUMBER** | SOCIAL SECURITY NUMBER | **RELATIONSHIP** | **PERCENT OF BENEFIT** |
|       |       |       |       |    % |
| HOME ADDRESS (1) | CITY | STATE | ZIP |
|       |       |       |       |
| NAME (2) | **PHONE NUMBER** | **SOCIAL SECURITY NUMBER** | **RELATIONSHIP** | **PERCENT OF BENEFIT** |
|       |       |       |       |    % |
| HOME ADDRESS (2) | CITY | STATE | ZIP |
|       |       |       |       |
| **NAME (3)** | **PHONE NUMBER** | SOCIAL SECURITY NUMBER | **RELATIONSHIP** | **PERCENT OF BENEFIT** |
|       |       |       |       |    % |
| HOME ADDRESS (3) | CITY | STATE | ZIP |
|       |       |       |       |
| **NAME (4)** | **PHONE NUMBER** | SOCIAL SECURITY NUMBER | **RELATIONSHIP** | **PERCENT OF BENEFIT** |
|       |       |       |       |    % |
| HOME ADDRESS (4) | CITY | STATE | ZIP |
|       |       |       |       |
| TOTAL FOR CONTINGENT BENEFICIARY (MUST EQUAL 100%) | TOTAL |
|  |    % |
| Page P Page 1 of 2 |
|  |
| SUBSCRIBER’S NAME (Last, First, MI) | SOCIAL SECURITY NUMBER | EMPLID | BIRTHDATE |
|  ,  |   |   |   |
|  |
|  |
| Estate, Trust, or Charity/Organization: [ ]  Primary [ ]  Contingent Proceeds assigned: \_\_   % |
| **NAME OF ENTITY** |
|       |
| CONTACT/ TRUSTEE NAME | PHONE NUMBER |
|       |       |
| HOME ADDRESS (1) | CITY | STATE | ZIP |
|       |       |       |       |
| **ENROLLMENT ACCEPTANCE** |
| I acknowledge that if I refuse or cancel this life insurance plan, the State Contribution will not be applied to reduce my medical plan cost or paid to me directly. I also understand by refusing this plan, I will be required to provide evidence of insurability acceptable to the insurance carrier in the future. I understand I have 31 days from my employment date to change my decision and participate in the Plan without evidence of insurability. By signing below, I hereby revoke any previous designations; and I designate the person, people or entity named herein as beneficiaries. |
| **Subscriber’s signature** | Date |
| **Insurance Representative’s Signature** | Date | Div/Dist/Troop |
| REFUSAL (complete when employee refuses to sign) |
| I certify that the benefits of the plan mentioned in this form were thoroughly explained to the employee and he/she has declined to participate; and refused to sign the above statement. |
| **Insurance Representative’s Signature** | Date      | Div/Dist/Troop      |

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