Print Form

DATE STAMP AREA

Department of Personnel Services

Employee Benefits Office
Dave Comerchero,
Employee Benefits Manager

County of Sacramento

LIFE INSURANCE BENEFICIARY FORM

Employee Name _____ Personnel Number_____

DOB_____ Hire Date_____ Email_____

PRIMARY BENEFICIARY INFORMATION-Benefits will be paid to the following person(s) in the event of your death

	#1	#2	#3
Full Name			
Birthdate/Relation			
Address/Zip			
Phone or Email			
Percentage-Total for all must equal 100%	%	%	%

CONTINGENT BENEFICIARY INFORMATION-If your primary designee is not living at the time of your death

	#1	#2	#3
Full Name			
Birthdate/Relation			
Address/Zip			
Phone or Email			
Percentage-Total for all must equal 100%	%	%	%

Complete below only if you named a minor child as a beneficiary

Minor child trustee_____ Relationship_____

Address/City/Zip_____

Phone_____ Email_____

This beneficiary designation revokes any previous designation; it takes effect on the day it is signed by the employee **and** filed with the employer. You may change the designation any time without the consent of the present/prior beneficiary.

_____ _____

EMPLOYEE SIGNATURE **DATE**

Employer Verification	Date