DESIGNATION OR CHANGE OF BENEFICIARY FORM
Local Life Insurance

_____ _____ - - _____

Name of Employee *Occupation* *Social Security Number*

☐ Male

☐ Female

_____ _____

Date of Birth *Date of Employment*

Primary Beneficiary (ies):

Name:	Name:
Address:	Address:
Relationship:	Relationship:
Date of Birth:	Date of Birth:
Social Security Number:	Social Security Number:

List contingent beneficiaries below.
Benefits are payable in equal shares to the primary beneficiary (ies) shown, if living, or to the survivors, otherwise to the named contingent beneficiary (ies) in equal shares or to the survivors unless otherwise specified.

_____ _____

Employee Signature *Date*

The right is reserved to revoke this designation and to designate new beneficiaries at any time by filing a new designation or Change of Beneficiary Form.

This request and authorization applies to any such plan of insurance as presently constituted or hereinafter changed for which I am or may become eligible and shall continue to apply until rescinded by me in writing.

Contingent Beneficiary (ies):

Name:	Name:
Address:	Address:
Relationship:	Relationship:
Date of Birth:	Date of Birth:
Social Security Number:	Social Security Number:

Name:	Name:
Address:	Address:
Relationship:	Relationship:
Date of Birth:	Date of Birth:
Social Security Number:	Social Security Number:

CHRISTINA SCHOOL DISTRICT
Educating each student to succeed