District Life Insurance
Designation of Beneficiary Form

Name of Employee ______ Occupation ______ Social Security Number ______

Date of Birth ______ ☐ Male ☐ Female Date of Employment ______

Primary Beneficiary(ies)

Name ______
Address ______
City, State & Zip ______
Relationship ______
Date of Birth ______
Social Security Number ______

Name ______
Address ______
City, State & Zip ______
Relationship ______
Date of Birth ______
Social Security Number ______

Contingent Beneficiary(ies)

Name ______
Address ______
City, State & Zip ______
Relationship ______
Date of Birth ______
Social Security Number ______

Name ______
Address ______
City, State & Zip ______
Relationship ______
Date of Birth ______
Social Security Number ______

Contingent Beneficiary (ies)

Name ______
Address ______
City, State & Zip ______
Relationship ______
Date of Birth ______
Social Security Number ______

Name ______
Address ______
City, State & Zip ______
Relationship ______
Date of Birth ______
Social Security Number ______

The right is reserved to revoke this designation and to designate new beneficiary(ies) 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as presently constituted or hereinafter changed for which I am or may become eligible and shall continue to apply until rescinded by me in writing.

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 ______

PLEASE FILL OUT COMPLETELY