Employee Benefits Insurance Beneficiary Change Form

Employee Information

Full Name

Employee ID

Department

Phone Number

Email Address

Current Insurance Plan(s)

Select Plan(s)

- Life Insurance
- Accident Insurance
- Critical Illness Insurance

Primary Beneficiary(ies)

Name	Relationship	Date of Birth	Share (%)	Address

Contingent Beneficiary(ies)

Name	Relationship	Date of Birth	Share (%)	Address

Authorization

Employee Signature

Date

Remarks