



Office use only	
Person ID _____	_____
Effective date _____	_____

Life Insurance and Accidental Death & Dismemberment Beneficiaries Form

EMPLOYEE INFORMATION

Last name _____ First name _____ Middle initial _____ Status UK KCTCS
 Person ID or Social Security number _____ Email address _____

PRIMARY BENEFICIARIES		Change in beneficiary? <input type="checkbox"/> Yes <input type="checkbox"/> No		AD&D	Life
Full name	Date of birth	Address	Social Security number	Relationship	Percentage*

*Percentages must add up to 100%

SECONDARY BENEFICIARIES		Change in beneficiary? <input type="checkbox"/> Yes <input type="checkbox"/> No		AD&D	Life
Full name	Date of birth	Address	Social Security number	Relationship	Percentage*

*Percentages must add up to 100%

I hereby designate the above person(s) to receive any benefit which may become due at or after my death according to the terms of the life insurance and AD&D insurance plans. I reserve the right to change this Beneficiary Designation with the understanding that this and any change thereof will be effective upon delivery to the Employee Benefits Office.

Signature _____ Date _____