Health Care Providers Group Insurance Plan
BENEFICIARY REQUEST

B1

PLEASE SEND COMPLETED FORM TO: INFO@HEALTHCAREPROVIDERS.CA

FIRST NAME: _____ **LAST NAME:** _____

PLAN MEMBER ID: _____

PART A - Change to Beneficiary Designation

I, _____ *, WISH TO*

☐ **Add a beneficiary** ☐ **Change the current beneficiary designation**

AND I UNDERSTAND THAT BY USING THIS FORM TO DESIGNATE OR CHANGE A DESIGNATION REVOKES ONLY THOSE NAMED BENEFICIARIES FOR THE COVERAGE INDICATED BY ME BELOW:

☐ **Basic Life and Basic ADD&D** ☐ **Optional Life**

I REVOKE ALL PREVIOUS BENEFICIARY DESIGATIONS FOR THE COVERGAE INDICATED ABOVE AND DECLARE THAT ALL BENEFITS PAYABLE UNDER THE POLICY AFTER MY DEATH FOR THE COVERAGE INDICATED ABOVE SHALL BE PAID ACCORDING TO THE FOLLOWING:

Primary Beneficiary(ies): *Required.* The first choice recipient(s) of the insured's death benefit.

First Name	Last Name	Relationship	% Allocated

Contingent Beneficiary(ies): *Optional.* The recipient(s) of the death benefit if the primary beneficiary dies before the insured.

First Name	Last Name	Relationship	% Allocated

Trustee: *Required for beneficiaries under age 18.* Person named to accept death benefit in trust on behalf of a minor.

First Name	Last Name	Relationship

* In the event that all beneficiaries predecease the employee, benefits shall be paid to the employee's estate.

I authorize all changes requested above to be made to my account

SIGNATURE: _____ **DATE:** _____