



HUMAN RESOURCES
 106 Whitehurst
 Stillwater, OK 74078
 (405) 744-5449

BENEFICIARY DESIGNATION FORM
 OSU Life Insurance Policies

CAMPUS WIDE ID: _____ EMPLOYEE NAME: _____

Beneficiary designations for OSU life insurance coverage become effective upon submission of this form and are applicable to all OSU life insurance policies. Any previous beneficiary designations become null and void with the proper completion of this form. In order to be valid, this form must be signed and dated prior to submitting it to OSU Benefits.

PRIMARY BENEFICIARIES			
NAME	ADDRESS, CITY, STATE & ZIP	RELATIONSHIP	BENEFIT % (must total 100%)
CONTINGENT BENEFICIARIES			
NAME	ADDRESS, CITY, STATE & ZIP	RELATIONSHIP	BENEFIT % (must total 100%)

CERTIFICATES OF INSURANCE: Certificates of insurance and plan summary documents are available through your Human Resources office or at <http://hr.okstate.edu/benefits/life>. Please review your certificates of insurance and plan summary documents to gain an understanding of the specific coverage and limitations of this benefit plan.

Print Name (or SIGN if submitting by mail or in person)

Date

An electronic signature is just as binding legally as a conventional, handwritten signature. When you submit, you are transmitting to us your consent to use your initials as your electronic signature for the elections you have entered. This submission must be emailed from your employee, OKSTATE, email address. Save this form and then submit using the EMAIL FORM option.

FOR OFFICE USE ONLY. VERIFIED BY: _____ DATE: _____