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BENEFICIARY DESIGNATION FORM
Oklahoma State University Life Insurance Policies

Campus Wide ID: _____ Employee Name: _____

Beneficiary designations for OSU life insurance coverage become effective upon completion 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*. 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 **DATE**

____ **(Initial)** An electronic signature is just as binding legally as a conventional, handwritten signature. When you click the "Submit" button above, you are transmitting to us your consent to use your initials as your electronic signature, for the elections you have just entered.

(***OFFICE USE)***

Verified By: _____ **DATE** _____