

STATE OF ARIZONA/BOARD OF REGENTS

BENEFICIARY FORM GROUP BASIC AND/OR SUPPLEMENTAL LIFE INSURANCE PLAN

Employee's Last Name	First Name	Middle Initial	Social Security Number	<input type="checkbox"/> Female	<input type="checkbox"/> Married
				<input type="checkbox"/> Male	<input type="checkbox"/> Single
Street Address		City	State	Zip Code	Work Phone No.

Name of Beneficiary	Social Security #	Relationship to Deceased	Date of Birth	Address & Phone Number of Beneficiary	Life Insurance Payment Options (Payable to Named Beneficiary)		
					Dollar Amt. To Each	Enter % paid to Each*	Equal Amt. To All <input type="checkbox"/>
PRIMARY BENEFICIARY							

CONTINGENT BENEFICIARY [Payable if primary (ies) deceased.]							

NAME OF WILL OR TRUST OR LEGAL AGREEMENT	DATE OF WILL OR TRUST	ADMINISTRATOR WHERE FILED	ADDRESS WHERE FILED

I agree that it is my obligation to keep these listings current with the Group Insurance Office.

Employee's Signature & Date

*The total percentage of benefits to all beneficiaries must equal 100%

NOTE: The social security number is used to ensure accurate processing of your life insurance claim.
BF-1 (10/94) Copies: White – GIO Canary – Agency Pink - Employee