**[Your Company Letterhead]**

**Employee Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name: |  | | |
| Employee ID: |  | Department: |  |
| Job Title: |  | Contact Number & Email: |  |

**Beneficiary Information:**

**Primary Beneficiary:**

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name: |  | | |
| Relationship: |  | Date of Birth: |  |
| Social Security number: |  | Address: | City, State, ZIP Code |
| Phone Number & Email: |  | Percentage of Benefit: | % $[amount] |

**Contingent Beneficiary (in case the primary beneficiary is not available):**

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name: |  | | |
| Relationship: |  | Date of Birth: |  |
| Social Security number: |  | Address: | City, State, ZIP Code |
| Phone Number & Email: |  | Percentage of Benefit: | % $[amount] |

**Insurance/Benefit Plan Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| Policy/Plan Name: |  | | |
| Policy/Plan Number: |  | Coverage Amount: |  |

**Employee Authorization:**

I hereby designate the individual(s) named above as my beneficiary (ies) to receive any benefits due under the specified insurance/benefit plan upon my death. I understand that this designation will remain in effect until I submit a written change.

|  |  |  |  |
| --- | --- | --- | --- |
| **Employee Signature:** |  | **Date:** |  |

**Witness Information:**

|  |  |
| --- | --- |
| I hereby certify that the above-named employee signed this Beneficiary Designation Form in my presence. | **Witness Name:** |
| **Witness Signature:** |
| **Date:** |
| **Address:** |

**For Office Use Only:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Received By** | **Date Received** | **Verified By** | **Date Verified** |
|  |  |  |  |

**HR Department Use Only:**

|  |  |  |
| --- | --- | --- |
| **Processed By** | **Date Processed** | **Comments** |
|  |  |  |

**Terms and Conditions:**

1. This form must be completed, signed, and submitted to the HR department.
2. Any changes to the beneficiary designation must be made in writing using a new Beneficiary Designation Form.
3. It is the employee’s responsibility to ensure that the beneficiary information is accurate and up to date.

[Place for other text]