Department of Personnel Services

Employee Benefits Office
Dave Comerchero,
Employee Benefits Manager

County of Sacramento

LIFE INSURANCE BENEFICIARY FORM

Employee Name _____PIN_____

DOB_____ Email_____

PRIMARY BENEFICIARY INFORMATION-Benefits will be paid to the following person(s) in the event of your death

Full Name	#1	#2	#3
Birthdate/Relation			
Address/Zip			
Phone or Email			
Percentage-Total for all must equal 100%	%	%	%

CONTINGENT BENEFICIARY INFORMATION-If your primary designee is not living at the time of your death

Full Name	#1	#2	#3
Birthdate/Relation			
Address/Zip			
Phone or Email			
Percentage-Total for all must equal 100%	%	%	%

Complete only if you named a minor child as a beneficiary

Trustee for Minor Child		Birthdate
Address/Zip		Phone

This beneficiary designation revokes any previous designation; it takes effect on the day it is signed by the employee and filed with the employer. You may change the designation at any time without the consent of the present beneficiary.

_____ _____

Employee Signature **Date**

Employer Signature	**Date**