

M-NCPPC Beneficiary Designation Form

Employee Name: _____ Employee ID Number: _____

Employee Email: _____

This designation applies to all coverages (Basic/AD&D/Supplemental) unless noted below:

Basic AD&D Supplemental (Note: Separate form required for each line of coverage.)

 If you need additional space to indicate your beneficiary designations, print another copy of this form to complete including the date and your signature.

PRIMARY BENEFICIARY(IES) – All beneficiaries in this section will be considered primary. Proceeds will be paid in equal shares to primary beneficiaries who survive unless you indicate percentages. Total percentage must equal 100%.

Primary Beneficiaries			
Beneficiary Full Name	Relationship	Address	Share % (total must equal 100%)
			%
			%
			%
			%

CONTINGENT BENEFICIARY(IES) – All beneficiaries in this section will be considered secondary. If no primary beneficiaries survive you, proceeds will be paid to the surviving secondary beneficiaries named in this section. Payment will be paid in equal shares unless you indicate percentages. Total percentage must equal 100%.

Contingent Beneficiaries			
Name	Relationship	Address	Share % (total must equal 100%)
			%
			%
			%
			%

Signature Required - This beneficiary form revokes all prior designations.

Employee's Signature: _____ Date: _____

For Office Use Only: HRIS: _____ Verified: _____

Return completed Beneficiary Designation Form with your signature to the Health & Benefits Office:

Mail: M-NCPPS, Health & Benefits Office Email: benefits@mncppc.org Fax: 301-454-1687
 6611 Kenilworth Avenue, Suite 404
 Riverdale, MD 20737