



Diocese of Cleveland Group Life Insurance Policy  
Beneficiary Designation

Form #101592

Ref. #: \_\_\_\_\_

NAME OF INSURED EMPLOYEE: \_\_\_\_\_

SSN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
NUMBER STREET APT #  
 \_\_\_\_\_  
CITY STATE ZIP

PHONE #: \_\_\_\_\_

*I hereby revoke any previous designation of beneficiary(ies) and designate the following:*  
 PRIMARY BENEFICIARY(IES): *(please print)*

1. \_\_\_\_\_  
FIRST NAME INITIAL LAST NAME RELATIONSHIP DATE OF BIRTH  
 RESIDING AT \_\_\_\_\_  
ADDRESS CITY STATE ZIP

2. \_\_\_\_\_  
FIRST NAME INITIAL LAST NAME RELATIONSHIP DATE OF BIRTH  
 RESIDING AT \_\_\_\_\_  
ADDRESS CITY STATE ZIP

3. \_\_\_\_\_  
FIRST NAME INITIAL LAST NAME RELATIONSHIP DATE OF BIRTH  
 RESIDING AT \_\_\_\_\_  
ADDRESS CITY STATE ZIP

*If more than one beneficiary is designated herein, payment shall be made in equal shares, or to the survivors in equal shares, or all to the last survivor.*

**CONTINGENT (Secondary) BENEFICIARY(IES) - *In the event the primary beneficiary(ies) predecease me, I hereby designate the following as contingent beneficiary(ies):***

1. \_\_\_\_\_  
FIRST NAME INITIAL LAST NAME RELATIONSHIP DATE OF BIRTH  
 RESIDING AT \_\_\_\_\_  
ADDRESS CITY STATE ZIP

2. \_\_\_\_\_  
FIRST NAME INITIAL LAST NAME RELATIONSHIP DATE OF BIRTH  
 RESIDING AT \_\_\_\_\_  
ADDRESS CITY STATE ZIP

3. \_\_\_\_\_  
FIRST NAME INITIAL LAST NAME RELATIONSHIP DATE OF BIRTH  
 RESIDING AT \_\_\_\_\_  
ADDRESS CITY STATE ZIP

*If more than one beneficiary is designated herein, payment shall be made in equal shares, or to the survivors in equal shares, or all to the last survivor.*

***I reserve the right to change this designation at any time.***

\_\_\_\_\_  
 SIGNATURE OF INSURED

\_\_\_\_\_  
 DATE SIGNED

*If this block is checked, it means you have submitted a separate page of additional beneficiary information due to lack of space on this form. A separate page must also be signed and dated by the insured in order to be valid.*