

Beneficiary Designation Form



HR-BEN-034

Section 1 - Information and Instructions	
<p>The purpose of this form is to update, add, or change a beneficiary designation to your life insurance coverage.</p> <p>Please fax a signed copy of the form to 212-852-8700 or email a signed copy to bscservice@mtabsc.org.</p> <p>If you have any questions, please contact the Business Service Center (BSC) at 646-376-0123 or bscservice@mtabsc.org.</p>	

Section 2 - Employee Information						
Print Name	Last First M.I. Suffix					BSC ID
Agency/Dept. (check one)	<input type="checkbox"/> BSC	<input type="checkbox"/> B&T	<input type="checkbox"/> CC	<input type="checkbox"/> HQ	<input type="checkbox"/> Police	Department
	<input type="checkbox"/> SIR	<input type="checkbox"/> LIRR	<input type="checkbox"/> MNR	<input type="checkbox"/> MTA Bus	<input type="checkbox"/> NYCT	
					<input type="checkbox"/> MaBSTOA	
Street Address						
City				State	Zip Code	
Phone (H)		Phone (W)			E-mail	
Date of Birth		Marital Status (check one box)				
Date of Hire		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated				

Section 3 - Life Insurance Beneficiary Designation Change Form		
<p>Check the appropriate box to indicate the Benefit Plan(s) that you are making beneficiary changes, updates, or additions to.</p>		
<input type="checkbox"/> Basic Life/ADD	<input type="checkbox"/> Supplemental Life	<input type="checkbox"/> Dependent Life

Section 4 - Beneficiary Designation					
<p>You may designate more than one person as your primary and/or contingent beneficiary. Use a separate sheet if more space is needed. Please print clearly.</p>					
A) Primary Beneficiary (ies): (In the column entitled "%" indicate the percent of benefits for beneficiary)					
Full Name	%	Date Of Birth	Social Security #	Relationship to Employee	Home Address (street, City, State, Zip code)
B) Contingent Beneficiary (ies): In the unfortunate circumstance something happens to the Primary Beneficiary, the contingent beneficiary will receive the benefits. (In the column entitled "%" indicate the percent of benefits for beneficiary)					
Full Name	%	Date Of Birth	Social Security #	Relationship to Employee	Home Address (street, City, State, Zip code)

Section 5 - Authorization		
<p>I hereby request, and am aware, that this change of beneficiary form that I have completed and submitted supersedes my previous beneficiary designation.</p>		
Employee Signature	Date	SSN Last 4 Digits