

Retiree Life Insurance Change/Cancel Form

Please select: Change Beneficiary Cancel Basic Life Cancel Supplemental Life

Name: _____ Date of Birth: _____

Social Security Number: _____ Phone Number: _____

Address: _____

BENEFICIARY DESIGNATION: *Please indicate Percent (%) allocated to each beneficiary – **total must equal 100% for Primary and/or Contingent sections.***

Primary Beneficiary Name	Date of Birth	Social Security Number (if available)	Phone Number	Relationship	Percent

Contingent (Secondary) Beneficiary Name	Date of Birth	Social Security Number (if available)	Phone Number	Relationship	Percent

Please include a copy of your Driver's license or I.D. for our records.

Signature: _____ Date Signed: _____

DO NOT WRITE BELOW THIS LINE- FOR HR PERSONNEL ONLY:

Group Number: 754292 Employee # _____ Received by: _____

Date Entered Into Lawson: _____ Initials: _____