RETIREE BENEFICIARY DESIGNATION FORM

Complete and return to ensure that we maintain your current information

Your Name (Print)			
Your Birthdate		**CWID or SSN**	
Mailing Address	Address City, State, Zip		
Telephone Number	Home: Cell:		
E-mail Address			
Please circle your associated institution: CSC LU NEO OPSU OSU			

If someone assists you with financial affairs, please provide their information below:

Name (Print)		**Relationship**:
Address	Address City, State, Zip	
Telephone Number	Home: Cell:	
E-mail Address		

RETIREE LIFE INSURANCE

Beneficiary designations become effective upon completion of this form. Any previous beneficiary designations become null and void with the proper completion of this form. To be valid, this form must be signed and dated prior to submitting it to OSU Benefits, 201 GAB, Stillwater, OK 74078.

PRIMARY BENEFICIARIES

NAME (Print)	**FULL ADDRESS**	**RELATIONSHIP**	**Benefit %** (must total 100%)

CONTINGENT BENEFICIARIES

NAME (Print)	**FULL ADDRESS**	**RELATIONSHIP**	**Benefit %** (must total 100%)

CERTIFICATES OF INSURANCE: Certificates of insurance and plan summary documents are available through your Human Resources office or at *http://hr.okstate.edu*. Please review your certificates of insurance and plan summary documents to gain an understanding of the specific coverage and limitations of this benefit plan.

SIGNATURE: _____ DATE: _____

(***OFFICE USE)*** Verified By:	Date: