

ADD/CHANGE OF BENEFICIARY DESIGNATION

Please attach to original enrollment form

POLICY # 01-020330-00

EMPLOYER/POLICYHOLDER NAME California Association of Professional Employees Benefit Trust

EMPLOYEE INFORMATION

NAME _____ **PHONE NUMBER** _____

STREET ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP CODE** _____

PRIMARY BENEFICIARY(IES):	
NAME	DATE OF BIRTH
ADDRESS	
RELATIONSHIP	BENEFIT PERCENT
NAME	DATE OF BIRTH
ADDRESS	
RELATIONSHIP	BENEFIT PERCENT

CONTINGENT BENEFICIARY(IES):	
NAME	DATE OF BIRTH
ADDRESS	
RELATIONSHIP	BENEFIT PERCENT
NAME	DATE OF BIRTH
ADDRESS	
RELATIONSHIP	BENEFIT PERCENT

DEFINITIONS

Primary Beneficiary: The person or persons you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

Contingent Beneficiary: The person or persons you want to receive the life insurance benefit if you die and if no primary beneficiary is alive on that date. If more than one contingent beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

EMPLOYEE SIGNATURE _____ **DATE SIGNED** _____