

Life Insurance Benefits Election Form

Personal Information

Full Name

Date of Birth

Employee ID

Address

City

State

ZIP Code

Insurance Coverage Election

Coverage Amount

 ▼

If Other, specify amount

Coverage Type

 ▼

Beneficiary Designation

Name	Relationship	Percentage	Contact
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Authorization & Signature

By signing below, I confirm the above selections and beneficiary designations for my life insurance plan.

Employee Signature

Date