

Life Insurance Benefits Election Form

Personal Information

Full Name

Date of Birth

Employee ID

Address

City

State

ZIP Code

Insurance Coverage Election

Coverage Amount

Select coverage amount

If Other, specify amount

Coverage Type

Select

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