

Primary Beneficiary Designation Form

Accident Insurance

Name of Insured

Policy Number

Date of Birth

Primary Beneficiary Information

Full Name	Relationship	Date of Birth	Percentage (%)
<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"/>

Total percentage must equal 100%.

Additional Instructions (optional)

Signature of Insured

Date

Please return completed form to your insurance carrier or plan administrator.