Retiree Beneficiary Designation Form

Last Name	First Name	(M.I.)

Street Address

City	State	Zip Code

Date of Birth	Date of Hire	Date of Retirement	Telephone #

Social Security #

Your Beneficiary Designation – The person(s) you designate below will receive the value of your life insurance if you die, and will supersede all previous beneficiary designations you have made. If you have previously named a beneficiary and do not want to make a change, leave this section blank.

Primary Beneficiary(ies) – If you name more than one primary beneficiary, they will share your life insurance benefits equally.

Name _____ Relationship _____

Address _____

Name _____ Relationship _____

Address _____

Name _____ Relationship _____

Address _____

Contingent Beneficiary (if any) – If you name a contingent beneficiary, he or she will receive your life insurance benefits only if your primary beneficiary(ies) die(s) before you.

Name _____ Relationship _____

Address _____

Name _____ Relationship _____

Address _____

If you need more space to name your beneficiary(ies), attach a separate sheet.

Your Signature – I certify that to the best of my knowledge, the above information is accurate. I understand that it is my responsibility to notify Montefiore's HR-Benefits Office if any of the above information changes.

Signature _____ Date _____

Complete this form and send a copy to:

Montefiore Medical Center
HR-Benefits Office
111 East 210th Street Bronx, NY 10467-2490
T 914.378.6531 F 914.378.6584
Email: montebenefits@montefiore.org

Montefiore