



On Your Side®

Submit Form to: Personnel Cabinet- Group Life Administration, 501 High Street, 2nd Flr, Frankfort, KY 40601

Section 1: Insured Information (Please complete all appropriate boxes in ink, printing legibly.)

Group Name Commonwealth of Kentucky	Group Number 90002
Employee Name (First, Middle Initial, Last)	Social Security Number
Subject to the terms and conditions of the above referenced Group Number, I request that any sum becoming payable by reason of my death be payable to the following beneficiary (ies). It is my understanding that this designation shall operate so as to revoke all designations of beneficiary (ies) previously made by me under the Group Policy.	
Employee Signature (Required)	Date (Required)

Note: Beneficiary designation is not valid unless this form and any separate accompanying sheets are signed and dated.

Section 2: Beneficiary Designation/Change (Please complete all appropriate boxes in ink, printing legibly. If you do not designate one or more beneficiaries, policy proceeds will be paid to your estate unless otherwise regulated by law.)

Basic Life and AD&D

Primary Beneficiary Information (Allocation to all Primary Beneficiaries must equal 100%)

Beneficiary Name and Address	Relationship	Date of birth	SSN (XXX-XX-XXXX)	% of Benefit

Contingent Beneficiary Information (Allocation to Contingent Beneficiaries must equal 100%)

Beneficiary Name and Address	Relationship	Date of birth	SSN (XXX-XX-XXXX)	% of Benefit

Optional Life and AD&D

Primary Beneficiary Information (Allocation to all Primary Beneficiaries must equal 100%)

Beneficiary Name and Address	Relationship	Date of birth	SSN (XXX-XX-XXXX)	% of Benefit

Contingent Beneficiary Information (Allocation to Contingent Beneficiaries must equal 100%)

Beneficiary Name and Address	Relationship	Date of birth	SSN (XXX-XX-XXXX)	% of Benefit

Section 3: General Information

- If more room is needed to indicate additional primary or contingent beneficiaries, please attach a separate sheet and list the information indicated above for each beneficiary. Please sign and date all additional sheets as well as this original form.
- Your group life coverage is issued by Nationwide Life Insurance Company, One Nationwide Plaza, MR-05-11 Columbus, OH 43215. Please refer to the Certificate of Insurance and Insurance Contract for all plan details, including any exclusions, limitations and restrictions which may apply.

Designation of Beneficiary (may be completed on-line using KHRIS Employee Self Service Center)

Instructions

- Print all information using black or blue ink.
- If additional space is needed, a separate paper listing all beneficiary information may be included. This paper must be signed and dated the same as the original form.
- Complete location name.
- Employee signature and date is required.
- Include the relationship of the beneficiary to the employee and the percentage of benefit to be paid.
- One or more beneficiaries may be named. If you do not name a beneficiary, or if you are not survived by one, benefits payable because of your death will be paid in equal shares to the first surviving class of the following: (a) Your spouse, (b) Your children, (c) Your parents, (d) Your brothers and sisters, and (e) Your estate. If utilizing KHRIS ESS, the Designation of Beneficiary will be effective immediately upon submission. If utilizing the paper form, the Designation of Beneficiary is not valid unless the form is signed and dated.
- The Designation of Beneficiary must be on file with your Employer and/or Life Insurance Branch at the time of your death to be accepted. KHRIS requires that all percentages be whole numbers. For example, an employee can no longer list 3 beneficiaries at 33 1/3% each. It must be entered as 33%, 33% and 34%. The percentages shall total 100%. Beneficiaries may be named or changed at any time without the consent of a beneficiary.
- If a trust or trustee is named beneficiary, the written trust must be identified in the beneficiary designation. For example, "Dorothy Q. Public, Trustee under the trust agreement dates _____." Show name and address of the trustee and effective date of the trust agreement.
- Insurance Coordinator should *verify all information*.