COBA MEMBERS TERMINATION PAY
BENEFICIARY DESIGNATION

☐ Initial Beneficiary Designation **OR** ☐ Change of All Prior Beneficiary Designation(s) (check one box only)

I hereby revoke any previous beneficiary designation(s), if any, for my termination pay and direct that the monies payable for termination pay be paid as indicated below.

Name	Social Security Number
Address	Telephone Number ( )

NAMING THE BENEFICIARY

It is important that your beneficiary designation be clear so that there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. When naming beneficiary(ies), please supply all requested information. If the beneficiary is not related either by blood or marriage, insert the words "Not Related". **NOTE:** Whether designating one or more beneficiaries, the total Benefit must equal 100%.

PRIMARY BENEFICIARY(IES) I hereby name the following beneficiary(ies). If I have named more than one beneficiary, it is my intention that those living at the time of my death share in the benefit payable as indicated below. I reserve the right to change this designation at any time.

Name: ____________________ Date of Birth: ____________

Address: ____________________

Social Security Number: ____________ Relationship: ____________

Benefit Percent: ____________

Name: ____________________ Date of Birth: ____________

Address: ____________________

Social Security Number: ____________ Relationship: ____________

Benefit Percent: ____________

CONTINGENT BENEFICIARY If all designated primary beneficiaries predecease me, any benefit payable on my behalf shall be paid to the following. If I have named more than one contingent beneficiary, it is my intention that those living at the time of my death should share in the benefit payable as indicated below. Furthermore, if I survive these beneficiaries, any benefit payable should be paid to my estate or any other beneficiary I name thereafter. I reserve the right to change this designation at any time.

Name: ____________________ Date of Birth: ____________

Address: ____________________

Social Security Number: ____________ Relationship: ____________

Benefit Percent: ____________

Payment Options

☐ Lump sum payment option

☐ Payment paid pursuant to Section 38-10.1 (D) of the Collective Bargaining Agreement

This form must be signed and notarized in order to be valid

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

Signature of Insured ____________________ Date ____________

State of ____________________ County of ____________________

Sworn before me this ____________ day of ____________ 20 ______

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Notary Public