



# Metro Nashville

## Life Insurance Beneficiary Designation/Change

Forward to:  
 Metro Human Resources  
 Attention: Benefit Services  
 Suite 1000  
 404 James Robertson Pkwy  
 Nashville, TN 37219

Before executing this form refer to the other side. Please keep a copy for your records.

Group Policyholder Name <b>Metropolitan Government of Nashville and Davidson County</b>	Group Policy Number <b>46767</b>	<input type="checkbox"/> Employee <input type="checkbox"/> Retiree	Employee/Retiree Social Security Number  Department:
Employee/Retiree Name and Address			Coverage(s) this form applies to: <ul style="list-style-type: none"> <li>• Basic Life Insurance</li> <li>• Supplemental Life</li> </ul>

Subject to the terms of the above numbered Group Policy(ies), 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 and all election of optional methods of settlement previously made by me under said Policy(ies). If this Designation of Beneficiary refers only to a Group Life Insurance Policy and if I am also insured for Supplemental and/or Group Accidental Death coverage, this designation shall apply to those coverages.

Employee/Retiree Signature	Date
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Beneficiary Name and Address	<input checked="" type="checkbox"/> <b>Primary Beneficiary*</b>	<input type="checkbox"/> <b>Basic Life Insurance</b>	<input type="checkbox"/> <b>Supplemental Life Insurance</b>
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Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage
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Beneficiary Name and Address	<input type="checkbox"/> <b>Primary Beneficiary*</b> <u>or</u> <input type="checkbox"/> <b>Contingent Beneficiary**</b>	<input type="checkbox"/> <b>Basic Life Insurance</b>	<input type="checkbox"/> <b>Supplemental Life Insurance</b>
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Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage
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Beneficiary Name and Address	<input type="checkbox"/> <b>Primary Beneficiary*</b> <u>or</u> <input type="checkbox"/> <b>Contingent Beneficiary**</b>	<input type="checkbox"/> <b>Basic Life Insurance</b>	<input type="checkbox"/> <b>Supplemental Life Insurance</b>
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Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage
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Beneficiary Name and Address	<input type="checkbox"/> <b>Primary Beneficiary*</b> <u>or</u> <input type="checkbox"/> <b>Contingent Beneficiary**</b>	<input type="checkbox"/> <b>Basic Life Insurance</b>	<input type="checkbox"/> <b>Supplemental Life Insurance</b>
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Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage
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If a Trust has been named as a beneficiary above, please complete the following:

Trustee's Full Name: \_\_\_\_\_

Trustee's Address: \_\_\_\_\_

Title of Trust Agreement: \_\_\_\_\_ Date of Agreement: \_\_\_\_\_

\*If more than one Primary Beneficiary is named, the Primary Beneficiaries shall share equally unless otherwise indicated above.  
 \*\*Contingent Beneficiary(ies) will only receive proceeds if all Primary Beneficiaries have predeceased the Insured. If you are naming more than one Contingent Beneficiary at 100% each, please indicate 1<sup>st</sup> contingent, 2<sup>nd</sup> contingent, 3<sup>rd</sup> contingent, etc. in the order of precedence.

