Metro Nashville

Life Insurance Beneficiary Designation/Change

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

Group Policyholder Name **Metropolitan Government of Nashville and Davidson County**	Group Policy Number **46767**	☐ Employee ☐ Retiree	Employee/Retiree Social Security Number Department:
Employee/Retiree Name and Address			Coverage(s) this form applies to: • Basic Life Insurance • Supplemental Life

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. Please keep a copy of this form for your records.

Employee/Retiree Signature	Date

Beneficiary Name and Address	☒ **Primary Beneficiary***	☐ **Basic Life Insurance**	☐ **Supplemental Life Insurance**
Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage

Beneficiary Name and Address	☐ **Primary Beneficiary*** or ☐ **Contingent Beneficiary****		☐ **Basic Life Insurance** ☐ **Supplemental Life Insurance**
Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage

Beneficiary Name and Address	☐ **Primary Beneficiary*** or ☐ **Contingent Beneficiary****		☐ **Basic Life Insurance** ☐ **Supplemental Life Insurance**
Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage

Beneficiary Name and Address	☐ **Primary Beneficiary*** or ☐ **Contingent Beneficiary****		☐ **Basic Life Insurance** ☐ **Supplemental Life Insurance**
Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage

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 1st contingent, 2nd contingent, 3rd contingent, etc. in the order of precedence.