## BENEFICIARY DESIGNATION FORM

## **NYSUT Member Benefits Trust-endorsed Term Life Insurance Plan**

Certificate Holder's Last Name		vanic	First Name			Middle Initial	
NYSUT Member's Social Security #  Street Address  City, State, Zip Code			NYSUT Member ID  Email Address			Phone Number Apt. #	
						include: (1) name	d indiv or und
		hat person's share will be equa		ng any ren	naining primary be		
Beneficiary Name	%	Address (Street/City/State/Zip)	Relationship	Date of Birth	Social Security or Tax I.D. Number	Phone Number	
eficiary(ies) are not	living a	ar second choice to receive you at the time of your death. If any mong any remaining continger  Address (Street/City/State/Zip)	contingent ben				
eficiary(ies) are not re will be equally di	living a	at the time of your death. If any mong any remaining continger	contingent bent beneficiaries.	Date of	Social Security or	nt person's	
eficiary(ies) are not re will be equally di	living a	at the time of your death. If any mong any remaining continger	contingent bent beneficiaries.	Date of	Social Security or	nt person's	
eficiary(ies) are not re will be equally di	living a	at the time of your death. If any mong any remaining continger	contingent bent beneficiaries.	Date of	Social Security or	nt person's	
eficiary(ies) are not re will be equally di	living a	at the time of your death. If any mong any remaining continger  Address (Street/City/State/Zip)	contingent bent t beneficiaries.  Relationship	Date of	Social Security or	nt person's	
eficiary(ies) are not re will be equally di Beneficiary Name	living a vided a %	AUTHORIZ on revokes any and all previous Administrator to pay any procurvives me or legally qualifies	r contingent bent to beneficiaries.  Relationship  ATION: as designations to be designations to be designations to be designations.	Date of Birth  I have ma o this desi	Social Security or Tax I.D. Number  de with respect to t gnation. If none of	Phone Numbe  Plan(s) noted the beneficiaries	
eficiary(ies) are not re will be equally dispensed and that this deve, and I authorize the ficated in this design ordance with the terminal of the second and the second an	living a vided a %	AUTHORIZ on revokes any and all previous Administrator to pay any procurvives me or legally qualifies	ATION:  as designations are as my beneficiaries.	Date of Birth  I have ma o this designary, I und	Social Security or Tax I.D. Number  de with respect to t gnation. If none of	he Plan(s) noted the beneficiaries will be made in	

## INSTRUCTIONS FOR COMPLETING A BENEFICIARY CHANGE FORM

The following instructions are included for your convenience.

- Type or print clearly in ink.
- Use new form instead of making erasures or corrections.
- Return all signed copies.
- The form must be received in our office within 45 days of the signature date.

If additional space is needed, please attach a separate sheet of paper. The certificate owner must sign and date each attachment.

If you are changing your beneficiary from a previously designated trustee beneficiary, please submit evidence that the Trust Instrument permits such a change.

If you are designating a trust as the primary or contingent beneficiary, please include a copy of the title page, the signature page, and the page that is notarized. Be advised that the notary's seal or stamp must be visible for us to accept your designation.

Please return your completed form to:

AMBA
PO BOX 14522
DES MOINES, IA 50306-3522

For your convenience, this form may be completed electronically by visiting www.nysutmbteinsurance.com and logging in to "MY ACCOUNT". Customer Service is available to assist you by calling (888) 386-9788.