



Beneficiary Designation Form

HR-BEN-034

Section 1 - Information and Instructions

The purpose of this form is to update, add, or change a beneficiary designation to your life insurance coverage.

Please fax a signed copy of the form to 212-852-8700 or email a signed copy to bscservice@mtabsc.org.

If you have any questions, please contact the Business Service Center (BSC) at 646-376-0123 or bscservice@mtabsc.org.

Section 2 - Employee Information

Print Name	Last First M.I. Suffix					BSC ID
Agency/Dept. (check one)	<input type="checkbox"/> BSC	<input type="checkbox"/> B&T	<input type="checkbox"/> CC	<input type="checkbox"/> HQ	<input type="checkbox"/> Police	Department
	<input type="checkbox"/> SIR	<input type="checkbox"/> LIRR	<input type="checkbox"/> MNR	<input type="checkbox"/> MTA Bus	<input type="checkbox"/> NYCT	
Street Address						
City				State	Zip Code	
Phone (H)			Phone (W)			E-mail
Date of Birth			Marital Status (check one box)			
Date of Hire			<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated			

Section 3 - Life Insurance Beneficiary Designation Change Form

Check the appropriate box to indicate the Benefit Plan(s) that you are making beneficiary changes, updates, or additions to.

Basic Life/ADD
 Supplemental Life
 Dependent Life

Section 4 - Beneficiary Designation

You may designate more than one person as your primary and/or contingent beneficiary. Use a separate sheet if more space is needed. Please print clearly.

A) Primary Beneficiary (ies): (In the column entitled "%" indicate the percent of benefits for beneficiary)

Full Name	%	Date Of Birth	Social Security #	Relationship to Employee	Home Address (street, City, State, Zip code)

B) Contingent Beneficiary (ies): In the unfortunate circumstance something happens to the Primary Beneficiary, the contingent beneficiary will receive the benefits. (In the column entitled "%" indicate the percent of benefits for beneficiary)

Full Name	%	Date Of Birth	Social Security #	Relationship to Employee	Home Address (street, City, State, Zip code)

Section 5 - Authorization

I hereby request, and am aware, that this change of beneficiary form that I have completed and submitted supersedes my previous beneficiary designation.

Employee Signature	Date	SSN Last 4 Digits
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