Office of Management and Enterprise Services
Employees Group Insurance Division
Beneficiary Designation Form

Please read the instructions carefully and complete this form in ink.

SSN or Member ID: ____________________ Member Name: ________________________________
First MI Last

Address: ____
☐ New Address Street City State ZIP

Beneficiary: Primary ☐ % (Optional): _______ Contingent ☐ % (Optional): _______
Full Legal Name of Person, Trust, or Institution: ______________________________
SSN: __________________ Date of Birth: ______________ Relationship: ________________
Address: ____
Street City State ZIP
Phone: (___) _________________________ Alt Phone: (___) _________________________

Beneficiary: Primary ☐ % (Optional): _______ Contingent ☐ % (Optional): _______
Full Legal Name of Person, Trust, or Institution: ______________________________
SSN: __________________ Date of Birth: ______________ Relationship: ________________
Address: ____
Street City State ZIP
Phone: (___) _________________________ Alt Phone: (___) _________________________

Beneficiary: Primary ☐ % (Optional): _______ Contingent ☐ % (Optional): _______
Full Legal Name of Person, Trust, or Institution: ______________________________
SSN: __________________ Date of Birth: ______________ Relationship: ________________
Address: ____
Street City State ZIP
Phone: (___) _________________________ Alt Phone: (___) _________________________

Beneficiary: Primary ☐ % (Optional): _______ Contingent ☐ % (Optional): _______
Full Legal Name of Person, Trust, or Institution: ______________________________
SSN: __________________ Date of Birth: ______________ Relationship: ________________
Address: ____
Street City State ZIP
Phone: (___) _________________________ Alt Phone: (___) _________________________

Signature – I have named the above beneficiary or beneficiaries to receive my life insurance benefits from HealthChoice. I understand this form replaces and cancels all prior beneficiary designations and will becomes effective only when it is received by EGID.

______________________________________ ____________________
Member Signature - original signature required Date

Mail this form to EGID at 3545 NW 58th Street, Suite 110, Oklahoma City, OK 73112

Revised 10/12/2012