

Wisconsin State Employee & Annuitant Benefits+ Beneficiary Designation Form

New Employee **Change in Beneficiary** **Other**

General Information

Employer/Former Employer Name		
Employee Name (First, Middle Initial, Last)		Date of Birth
Address ZIP	City	State
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Group Number	Customer Number

Beneficiary Designation

For more space, use a separate sheet and mark the following box: **More Beneficiaries Attached**

Please Note: *Contingent beneficiary(ies) receive payment only if all primary beneficiary(ies) are deceased or are otherwise disqualified by law. If more than one primary or contingent beneficiary is designated, payment of proceeds will be made in equal shares to the named beneficiary(ies), unless otherwise noted on this designation form.*

Coverage	Primary Beneficiary		% of Benefit
Benefits+ Hospital Surgery and AD&D Benefit	Name & Relationship Last 4 digits of SSN & DOB Address		____%

	Name & Relationship Last 4 digits of SSN & DOB Address		____%
	Contingent Beneficiary		Total=100%
	Name & Relationship Last 4 digits of SSN & DOB Address		____%

			Total=100%

Employee Signature: _____ **Date:** _____

This form replaces all prior beneficiary designations. Please mail to The EPIC Life Insurance Company, Attention: Life & Disability Department, P.O. Box 8430, Madison, WI 53708-8430 or fax to (608) 977-9861.

Spousal Waiver



I understand that by signing below, I am waiving my rights to the proceeds of this EPIC Life Insurance Policy. This will waive the spouse's rights to benefits.

Spousal Waiver Signature: _____ Date: _____