Instructions for Completing Beneficiary Designation Form

You must complete a Beneficiary Designation Form if you are a new Participant in the Plan or if you are changing your beneficiary for life insurance.

Changing Your Beneficiary for Life Insurance

- A new Beneficiary Designation Form must be completed in its entirety.
- The Beneficiary Designation Form **must be signed** for the change of beneficiary to become effective.

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BENEFICIARY DESIGNATION FORM

COMPLETE BOTH PAGES OF THIS FORM , SIGN AND DATE WHERE INDICATED, AND RETURN TO THE PLAN OFFICE IN BALTIMORE

Member Name			
	Last Name First Name Initial		
Social Security Number			
Date of Birth (mm/dd/yyyy)		Sex (Select one)	○ Male ○ Female
Home Telephone Number	(Area Code:)		
Cellular Phone Number	(Area Code:)		
E-mail address (If applicable)	@		
Affiliation (Check One)	☐ District No. 1-PCD, MEBA ☐ Plan Employee ☐ Union Employee ☐ Other:		
Active/Pensioner (Check One)	☐ Active ☐ Pensioner	If Actively Employed, Name of Present Employer:	
Marital Status (Check One)	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated		

BENEFICIARY DESIGNATION FORM

I designate the following person(s) as my beneficiary (ies) to receive benefits which may be payable from the MEBA Medical and Benefits Plan upon my death. I revoke all previous beneficiary designations and make the designation of beneficiary(ies) shown below with respect to benefits provided now or at any time in the future under the above Plan, still reserving to myself the privilege of making other and future changes subject to the Plan provisions. If more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiaries (or beneficiary) as survive me, unless otherwise provided herein (total must equal 100%). If no beneficiary survives me, settlement will be made in accordance with the provisions of the Plan. **NOTE: Co-beneficiaries receive proceeds in equal shares, unless otherwise indicated. Contingent Beneficiary is the person who will receive the proceeds if the primary beneficiary should predecease the person whose life is insured.**

Name: **Check One:** ○ Beneficiary ***or*** ○ Co-Beneficiary			
	Last Name First Name Initial Relationship		
Address of Beneficiary			
	Number & Street City State Zip		
Beneficiary's Social Security Number		Percent (%) of Benefit:	_____%
Date of Birth (mm/dd/yyyy)		Sex (Check One)	○ Male ○ Female

Revised 12/2010

CO-BENEFICIARY (IES) OR CONTINGENT BENEFICIARY (IES)

Name: **Check One:** ○ Beneficiary ***or*** ○ Co-Beneficiary				
	Last Name	First Name	Initial	Relationship
Address of Beneficiary				
	Number & Street	City	State	Zip
Beneficiary's Social Security Number			Percent (%) of Benefit:	_____%
Date of Birth (mm/dd/yyyy)		Sex (Check One)	○ Male ○ Female	
Name: **Check One:** ○ Co-Beneficiary ***or*** ○ Contingent Beneficiary				
	Last Name	First Name	Initial	Relationship
Address of Beneficiary				
	Number & Street	City	State	Zip
Beneficiary's Social Security Number			Percent (%) of Benefit:	_____%
Date of Birth (mm/dd/yyyy)		Sex (Check One)	○ Male ○ Female	

Name: **Check One:** ○ Co-Beneficiary ***or*** ○ Contingent Beneficiary				
	Last Name	First Name	Initial	Relationship
Address of Beneficiary				
	Number & Street	City	State	Zip
Beneficiary's Social Security Number			Percent (%) of Benefit:	_____%
Date of Birth (mm/dd/yyyy)		Sex (Check One)	○ Male ○ Female	

(Attach a separate sheet to your Permanent Data Form if you have more than two Co-Beneficiaries)

Signature of Employee		Date	

FORM IS NOT VALID IF NOT SIGNED AND DATED BY PARTICIPANT
FORM WILL BE RETURNED IF NOT SIGNED AND DATED.

Revised 12/2010