Ball State University/CIGNA

Group Life Insurance Beneficiary Designation/Change Form and Deduction Authority

Account Number 11439

Please print all information legibly except where signature is required.

Employee Information

Last Name	*First Name*	*MI*

Ball State ID Number	*Date of Birth*	*Date of Hire*

Beneficiary Information

Please list all PRIMARY beneficiaries (Primary Beneficiaries are the designated beneficiaries for your life insurance benefit) and the percent of benefit they are to receive. You may hae one or more than one beneficiary. Percentages should equal 100%.

Primary Beneficiary Name	Relationship	Current Address	Percentage

Please list all CONTINGENT beneficiaries (Contingent Beneficiaries receive the benefit if both you and your primary beneficiary(ies) are deceased; otherwise, they do not receive any benefit). Naming a Contingent Beneficiary is optional.

Contingent Beneficiary Name	Relationship	Current Address	Percentage

Signature

I hereby certify that the foregoing information is true and correct to the best of my knowledge. The Information stated above supersedes all prior beneficiary designations I may have completed.

For Beneficiary Designations to the Ball State University Foundation (optional): I further acknowledge that if I choose to designate the Ball State Foundation as my beneficiary, in part or in whole, I am returning this completed designation form to their attention where my designation will be recorded, and as a result, the Foundation will have full knowledge of the designation. Further, I understand that the Ball State Foundation will ensure that the Payroll & Employee Benefits department is forwarded this Beneficiary Designation in a timely manner following recording of my designation by the Foundation.

I hereby accept the forms of group insurance presently contracted for by my employer with CIGNA in the amount(s) for which I am or may become eligible, and authorize until revoked by me in writing the deduction by my employer from my earnings of amounts sufficient to cover my contributions toward the premium under the said group insurance contractor(s).

Signature (required)	*Date Signed*