

Public Employees Health Programs

560 East 200 South, Suite 100
 Salt Lake City, Utah 84102-2004
 Term Life (801) 366-7495
 Toll Free (800) 753-7495

**Line of Duty
 Beneficiary Form**

Section A - Employee Information

Employee Name (First, Middle, Last)	Daytime Phone	Birth Date (mm/dd/yy)	Social Security Number
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Section B - Beneficiary

Revoking any previous nominations of beneficiary(ies), I hereby designate the following individual(s) to receive all benefits payable upon my death.

Full Given Name of Beneficiary	Designation <input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Relationship	Birthdate	Mailing Address		
				Street	City	State Zip
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street	City	State Zip
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street	City	State Zip
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street	City	State Zip
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street	City	State Zip
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street	City	State Zip
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street	City	State Zip
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street	City	State Zip
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street	City	State Zip
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street	City	State Zip
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street	City	State Zip

Is this a change in beneficiary designation? Yes No

Employee Signature	Date
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