OKLAHOMA
Office of Management
& 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

Phone: (____) _____ Alt Phone: (____) _____

Important*: Please ensure the "Share Percentage" section in both Primary Beneficiary(ies) and Contingent Beneficiary(ies) add up to 100 percent. Payment will be made in equal shares to all surviving beneficiaries unless otherwise indicated.

PRIMARY BENEFICIARY(IES)

Primary Beneficiary's Name and Address	SSN	Phone #	Relationship	Date of Birth	Share Percentage
					100%

CONTINGENT BENEFICIARY(IES)

Proceeds are paid to the contingent beneficiary(ies) identified below only if there is no surviving primary beneficiary(ies).

Contingent Beneficiary's Name and Address	SSN	Phone #	Relationship	Date of Birth	Share Percentage
					100%

I have named the above beneficiary(ies) to receive my life insurance benefits from HealthChoice. I understand this form replaces and cancels all prior beneficiary designations and will become effective only when it is received by EGID.

_____ _____
Member Signature - original signature required Date

Mail this form to OMES EGID at P.O. Box 11137, Oklahoma City, OK 73136-9998