VFIS®

# Beneficiary Designation for Accident & Sickness Policy

Complete this block each time this form is used – Please Print

Name of Organization: Boone County Fire Protection District

Member's/Employee's Name:_____

Member's/Employees Date of Birth: _____

Date Member/Employee Joined Organization: _____

Complete, sign and date this block if you wish to name or change your beneficiary.

.

I hereby designate the following beneficiary(ies) with respect to amounts payable as indemnity for loss of life under the referenced Accident & Sickness Policy and hereby revoke any designation of beneficiary thereunder heretofore made by me. I direct that any amounts payable under said Policy to my beneficiary who survive me, otherwise to those surviving in Contingent Beneficiary, in proportion to the percentages listed.

**Primary Beneficiary**

Name:_____Relationship:_____

Date of Birth:_____ Share:_____%

Name:_____Relationship:_____

Date of Birth:_____ Share:_____%

**Contingent Beneficiary**

Name:_____Relationship:_____

Date of Birth:_____ Share:_____%

Name:_____Relationship:_____

Date of Birth:_____ Share:_____%

If none of the above-named beneficiaries are living at the time of my death, I direct that payment be made in accordance with the terms of the policy. I reserve the right to revoke or change this designation.

Signature_____ Date:_____

**This form should be retained in the files of your department or organization**