The Benefits of Caring

Catholic Health Services of Long Island – Beneficiary Designation Form

Instructions: Please access www.benefitsquest.com/chsli for a description of benefits offered by your employer. Please print clearly. Return this form to the Human Resources Department.

I am a: ❑ **Full-time employee** ❑ **Benefit Eligible Part-time employee** **Organization/Location:**_____

Employee Information:

Name: _____ **SSN:** _____ **Birth Date:** ___/___/____

Home Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Date of Hire:** _____ **Sex:** ❑ Male ❑ Female

Cell Phone: _____ **E-mail Address:** _____

Marital Status: ❑ Single ❑ Married **Employee #:** _____

Life and Accidental Death & Dismemberment (AD&D) Beneficiary(ies) — The beneficiary designation(s) made below is(are) for all benefits payable under my employer's Life and AD&D Insurance plans, which automatically provide a benefit equal to one times your annual salary. This designation will cancel any previous designation. When I name more than one beneficiary, payment will be made in equal amounts, unless otherwise specified. Benefits will be paid to the Contingent Beneficiary if the Primary Beneficiary is deceased. In the event that all beneficiaries are deceased or no beneficiaries are on file, benefits will be paid as provided in the group policy. (If additional space is required, please attach a separate sheet.)

Beneficiary(ies)	**Name (Last, First, MI):**	**Birth Date**	**SSN**	**Relationship to you**	**% of Benefit**	**Address** (if different from your own)
❑ Primary		/ /				
❑ Primary		/ /				
❑ Contingent		/ /				

Employee's Signature: _____ Date: _____