



MERIDIAN HEALTH LIFE INSURANCE ***BENEFICIARY ELECTION FORM***

Participant's Name: _____
(Please Print Name)

Team Member ID #: _____ Last 3 digits of SSN: _____

Please name a beneficiary for both Core and Optional Life Insurance. Please note, if no beneficiary is designated for Core and Optional Life, proceeds will be paid to your estate. For Spousal and Dependent life insurance, you (the employee) will automatically be the beneficiary.

You may change your beneficiaries at any time by completing a new form. If you need additional space, please continue on a second page.

PRIMARY BENEFICIARIES

Beneficiary Name (Last, First, MI)	Social Security Number	Relationship	% of Benefit (Combined Total Must = 100%)
TOTAL			100%

CONTINGENT / SECONDARY BENEFICIARIES

Beneficiary Name (Last, First, MI)	Social Security Number	Relationship	% of Benefit (Combined Total Must = 100%)
TOTAL			100%

Under the penalties of perjury, I certify that the information that is provided on this form is true, correct, and complete.

Participant's Signature _____

Date _____

Return Completed Form to Corporate Human Resources:

*Meridian Health
Corporate Human Resources
1430 Route 34
Neptune, NJ 07753-6807
Attention: Benefits Department*