HSTA VEBA TRUST

Life Insurance Beneficiary Designation/Name Change Form

LB-1

Policyholder: **HSTA Voluntary Employees Beneficiary Association Trust**	Group Policy Number ☐ **BASIC 41000-01** ☐ **BASIC PLUS 41000-102**
Employee/Retiree Last Name, First, M.I.	Social Security Number:
Mailing Address:	**Name Change**: ❑ Employee ❑ Beneficiary
City: State: Zip Code:	Formerly (Last, First MI):

Instructions for Changing Beneficiary:

- If more than one primary beneficiary is named, the primary beneficiaries shall share equally unless otherwise indicated above.
- Contingent Beneficiary(ies) will only receive proceeds if all Primary Beneficiaries have predeceased the Insured. If more than one contingent beneficiary is named, the contingent beneficiaries shall share equally unless otherwise indicated.

Beneficiary Information

Name (last, first, mi):	Relationship:	Primary ☐	
Address:	SSN:	DOB:	
Name (last, first, mi):	Relationship:	Primary ☐	Contingent ☐
Address:	SSN:	DOB:	
Name (last, first, mi):	Relationship:	Primary ☐	Contingent ☐
Address:	SSN:	DOB:	
Name (last, first, mi):	Relationship:	Primary ☐	Contingent ☐
Address:	SSN:	DOB:	
Name (last, first, mi):	Relationship:	Primary ☐	Contingent ☐
Address:	SSN:	DOB:	

Subject to the terms of the above Group Policy, I request that any sum becoming payable by reason of my death be payable to the following beneficiary(ies). It is my understanding that this designation shall operate so as to revoke all designations of beneficiary and all elections of optional methods of settlement previously made by me under said Policy.

Employee Signature: ____Date:________________

HSTA-VEBA Trust use	Effective/Change Date:	Termination Date: