THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA

TERM LIFE INSURANCE BENEFICIARY DESIGNATION FORM

PLEASE PRINT

Employee Last Name _____ First Name _____ M.I. ____

Social Security # _____-_____-_____ Employee ID # _____

Work Location Name: _____ Facility # _____

BOARD PAID LIFE INSURANCE

Primary Name(s): PLEASE PRINT — Relationship: — %

Last	First	M.	DOB	Relationship	SSN	%

Contingent(s) *(if any):*

Last	First	M.	DOB	Relationship	SSN	%

SUPPLEMENTAL LIFE INSURANCE

☐ **Yes, I wish to purchase:** ☐ **1x -OR-** ☐ **2x** ☐ **No, I do not wish to purchase**

(Cost is less than $.10 per thousand dollars)

Primary Name(s): PLEASE PRINT — Relationship: — %

Last	First	M.	DOB	Relationship	SSN	%

Contingent(s) *(if any):*

Last	First	M	DOB	Relationship	SSN.	%

The designations above will remain in effect indefinitely unless I authorize changes.

Employee Signature _____ Date_____