

**J.J. STANIS AND COMPANY, INC**  
**377 OAK STREET, SUITE 406 GARDEN CITY, NY 11530**  
**PHONE: (516) 465-3900 FAX#: (516) 465-3920 WEBSITE: WWW.JJSTANISCO.COM**

**REQUEST FOR CHANGE OF BENEFICIARY FORM**

**NORTH SALEM CSD**

Type of Coverage:	<b>GROUP LIFE INSURANCE</b>			
<b>A. Employee Information</b>				
Name (Last, First)			Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:
Street Address			Date of F/T Hire	
City	State	Zip	Hours worked per week	
Social Security No.				
Job Title		Home Phone	Cell Phone	
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			

<b>B. Primary Beneficiaries</b>				
I hereby designate the following as my beneficiary(ies) under the above group policy:				
Name (Last, First)	Social Security No.	Address	Benefit %	Relationship
Name (Last, First)	Social Security No.	Address	Benefit %	Relationship
Name (Last, First)	Social Security No.	Address	Benefit %	Relationship
Name (Last, First)	Social Security No.	Address	Benefit %	Relationship
Name (Last, First)	Social Security No.	Address	Benefit %	Relationship
Contingent Beneficiary(ies): If the beneficiary(ies) above are not living, then pay:				
Name (Last, First)	Social Security No.	Address	Benefit %	Relationship
Name (Last, First)	Social Security No.	Address	Benefit %	Relationship
Name (Last, First)	Social Security No.	Address	Benefit %	Relationship
Name (Last, First)	Social Security No.	Address	Benefit %	Relationship
If not percentages are indicated, benefits will be divided equally between all primary beneficiaries. If you are designating percentages, they must equal 100.				

**This beneficiary designation revokes all revocable prior beneficiary designations.**

**Employee Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Witness Signaure:** \_\_\_\_\_

**Date:** \_\_\_\_\_

(Witnessed by someone other than a named Beneficiary)