University of Missouri – Retiree Beneficiary Designation Information

Retiree Last Name	Retiree First Name		MI	Retiree ID (not SSN)	
Residential Street Address (not P.O. Box)	City	State	Zip	Phone Number	Effective Date of Change

Please complete the following beneficiary designation. If there are any additional beneficiary(ies) beyond those that will fit on this form, list them on a separate sheet. Return completed form to:
University of Missouri System, Office of Human Resources

- Email: hrservicecenter@umsystem.edu
- Fax: (573) 882-9603
- Mail: 1000 W. Nifong Blvd., Building 7, Suite 210, Columbia, MO 65211-8220

Basic Life Insurance Plan Beneficiary(ies)

Primary

1) Name	Date of birth	Relationship	Social Security number	Share (%)
Address			Phone Number	
2) Name	Date of birth	Relationship	Social Security number	Share (%)
Address			Phone Number	

Contingent

1) Name	Date of birth	Relationship	Social Security number	Share (%)
Address			Phone Number	
2) Name	Date of birth	Relationship	Social Security number	Share (%)
Address			Phone Number	

Accidental Death & Dismemberment Insurance Plan Beneficiary(ies)

Primary

☐ **Beneficiary(ies) same as Life Insurance**

1) Name	Date of birth	Relationship	Social Security number	Share (%)
Address			Phone Number	
2) Name	Date of birth	Relationship	Social Security number	Share (%)
Address			Phone Number	

Contingent

1) Name	Date of birth	Relationship	Social Security number	Share (%)
Address			Phone Number	
2) Name	Date of birth	Relationship	Social Security number	Share (%)
Address			Phone Number	

Additional Life Insurance Plan Beneficiary(ies)

Primary

☐ **Beneficiary(ies) same as Life Insurance**

1) Name	Date of birth	Relationship	Social Security number	Share (%)
Address			Phone Number	
2) Name	Date of birth	Relationship	Social Security number	Share (%)
Address			Phone Number	

Required Signature on Page 2

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Retiree Last Name	Retiree First Name	MI	Retiree ID (not SSN)

Additional Life Insurance Plan Beneficiary(ies) - Continued

Contingent

1) Name	Date of birth	Relationship	Social Security number	Share (%)
Address			Phone Number	
2) Name	Date of birth	Relationship	Social Security number	Share (%)
Address			Phone Number	

Election/Authorization

I hereby designate the above beneficiary(ies) to receive applicable benefits under the plans identified. I hereby revoke any and all previous beneficiary designations.

I acknowledge and agree that this document may be signed by electronic signature, which shall be considered an original signature for all purposes and shall have the same force and effect as an original signature. "Electronic signature" shall include faxed versions of an original signature, electronically scanned and transmitted versions of an original signature, and typed signature in a fillable form or typed signature via Adobe Pro.

_____ _____

Signature of Retiree / Authorized Signee (Required) **Today's Date (Required)**