Website Form

TEXAS MEDICAL ASSOCIATION INSURANCE TRUST
BENEFICIARY CHANGE FORM

Name of insured: _____ _____ _____ **Certificate #:** _____

Date of Birth _____ **Gender** ☐Male ☐Female **Marital Status** (check one) ☐Married ☐Widowed ☐Single ☐Divorced

Street Address: _____ City: _____ State: _____ Zip Code:_____

Daytime Phone: _____

Please list the product(s) for which the designation applies: (Example: Member Term Life, Personal Accident, Employee Life Insurance)

Product: _____ **Has insurance ever been assigned?** ☐Yes ☐No

I hereby revoke any previous designations of primary beneficiary(ies) and contingent beneficiary(ies), if any, and in the event of my death designate the following:

Primary Beneficiary(ies)

Name and Address	Phone Number	Social Security Number /Tax ID	Relationship to you	Date of Birth	Percentage (must equal 100%)
Name: Address:					
Name: Address:					
Name: Address:					

☐ If submitting electronically, checking this box serves as proof of signature.

_____ _____

Signature Date