TOWN OF BROOKLINE
LIFE INSURANCE BENEFICIARY CARD

Group Policy Number

Effective Date

Department

Position

Date Hired / /

Date of Birth / /

Sex

NAME OF EMPLOYEE (please print)

SOCIAL SECURITY NUMBER -- --

NAME OF BENEFICIARY

RELATIONSHIP

Primary Beneficiary

Contingent Beneficiary (ies)

I apply for the insurance for which I am now eligible or for which I may become eligible under the provisions of the Group Policy or Group Policies issued to my employer and authorize deductions, if any, of the required premium contribution toward the cost of the insurance. I understand that if I am disabled on the date my insurance would otherwise become effective, I shall only become insured on the date I return to active full-time work.

DATE _____ SIGNATURE OF EMPLOYEE _____

EMPLOYER/OFFICE USE ONLY [Please do not write in this area]

Initial amount(s) of insurance: Life _____ A & S _____ AD& D _____ HL AD&D _____

Authorized Signature (Personnel Office): _____