

CHANGE BENEFICIARY FORM

**New Mexico Retiree
Health Care Authority**

6300 Jefferson St NE, Suite 150
Albuquerque, NM 87109
1 (800) 233-2576

A Retiree / Surviving Dependent Personal Information — *Please PRINT clearly.*

1. Social Security No.	2. Last Name	First Name	MI	3. Date of Birth
4. E-mail Address	5-a. Mailing Address			
6. Effective Date of Change	b. City	c. State	d. ZIP Code	e. Home/Mobile Phone ()

B Change Beneficiary(ies) for Retiree / Surviving Dependent Life Policy(ies)

I wish to change my life insurance beneficiary(ies); following is a *new* list of *ALL* my beneficiaries. *Any previously named beneficiary not listed on this form will be considered to have been removed. Complete items a-h for each named beneficiary and indicate the percentage of your life insurance you wish the beneficiary to receive.*

Primary Beneficiary(ies)

1a. Full Name	b. Relationship	c. Social Security No.	d. Telephone No. () —
e. Mailing Address	f. City	g. State	h. ZIP Code % of benefit _____%
2a. Full Name	b. Relationship	c. Social Security No.	d. Telephone No. () —
e. Mailing Address	f. City	g. State	h. ZIP Code % of benefit _____%
3a. Full Name	b. Relationship	c. Social Security No.	d. Telephone No. () —
e. Mailing Address	f. City	g. State	h. ZIP Code % of benefit _____%
4a. Full Name	b. Relationship	c. Social Security No.	d. Telephone No. () —
e. Mailing Address	f. City	g. State	h. ZIP Code % of benefit _____%

Attach additional sheet if necessary.

Contingent Beneficiary(ies)

1a. Full Name	b. Relationship	c. Social Security No.	d. Telephone No. () —
e. Mailing Address	f. City	g. State	h. ZIP Code % of benefit _____%
2a. Full Name	b. Relationship	c. Social Security No.	d. Telephone No. () —
e. Mailing Address	f. City	g. State	h. ZIP Code % of benefit _____%
3a. Full Name	b. Relationship	c. Social Security No.	d. Telephone No. () —
e. Mailing Address	f. City	g. State	h. ZIP Code % of benefit _____%

Attach additional sheet if necessary.

C RETIREE / SURVIVING DEPENDENT SIGNATURE

(If signing under power of attorney, please attach authorizing document.)

Signature _____ **Date** _____

Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries:
 1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
 2. If you provide for unequal shares, and two or more Beneficiaries survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
 3. If only one Beneficiary survives, we will pay the total death benefits to that Beneficiary.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, “Dorothy Q. Smith, Trustee under the trust agreement dated _____”.
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have any questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your coverage under the Group Policy.