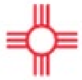

NEW MEXICO
RETIREE HEALTH CARE
AUTHORITY

Life Insurance Beneficiary Change Form

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

Internal Use ONLY:
Contract Holders SSN
Received Stamp Date:
CSR INT: __________ CareView: ☐

PERSONAL INFORMATION

Contract Holders Name: (Last, First, MI)	SSN or RHCA ID:	Date of Birth: (mm/dd/yy)	
Physical Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:

BENEFICIARY INFORMATION: Your designation revokes all prior designations. Please indicate percentage of your life insurance you wish the beneficiary or each beneficiary to receive.

Primary Beneficiary

1. Type/Relation:	Name:		SSN:	Phone #:
Address:	City:	State:	Zip:	% Of Benefit:
2. Type/Relation:	Name:		SSN:	Phone #:
Address:	City:	State:	Zip:	% Of Benefit:
3. Type/Relation:	Name:		SSN:	Phone #:
Address:	City:	State:	Zip:	% Of Benefit:
4. Type/Relation:	Name:		SSN:	Phone #:
Address:	City:	State:	Zip:	% Of Benefit:

Contingent Beneficiary (Back-Up)

1. Type/Relation:	Name:		SSN:	Phone #:
Address:	City:	State:	Zip:	% Of Benefit:
2. Type/Relation:	Name:		SSN:	Phone #:
Address:	City:	State:	Zip:	% Of Benefit:
3. Type/Relation:	Name:		SSN:	Phone #:
Address:	City:	State:	Zip:	% Of Benefit:
4. Type/Relation:	Name:		SSN:	Phone #:
Address:	City:	State:	Zip:	% Of Benefit:

CONTRACT HOLDER SIGNATURE (if signing under power of attorney, please attach supporting documentation)

Contract Holders Signature ______________________ Date ______________

(Please attach additional sheets if necessary)