National Guard Association of Kansas Beneficiary Designation

GROUP CUSTOMER INFORMATION

Name of Policyholder: **Patriots Insurance Trust**	Customer #: **251888**	Group/Report #: **2**60990

INSURED INFORMATION

Member's Name (First, Middle, Last)

Address (Street, City, State, Zip Code):

Phone #: | Email: | SSN #: | DOB:

BENEFICIARY DESIGNATION FOR MEMBER INSURANCE

Primary beneficiary - Your first choice to receive your life insurance proceeds in the event of your death. If any primary beneficiaries predecease you, that person's share will be equally divided among any remaining primary beneficiaries. The sum of the Primary Beneficiary percentages **MUST equal 100%.** I designate the following person(s) as **primary beneficiary(ies)** for any amount payable upon my death for the term life insurance under the group policy indicated on this form.

☐ Check if you need more space for additional beneficiaries, attach a separate page. Include all beneficiary information, and sign/date the page.

Full Name (First, Middle, Last)	DOB (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)		Phone #	
Full Name (First, Middle, Last)	DOB (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)		Phone #	
Full Name (First, Middle, Last)	DOB (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)		Phone #	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.		**TOTAL:**	100%

Contingent beneficiary - Your second choice to receive your life insurance proceeds if ALL of your primary beneficiary(ies) are not living at the time of your death. If any contingent beneficiaries predecease you, that person's share will be equally divided among any remaining contingent beneficiaries. The sum of the Contingent Beneficiary(ies) percentages **MUST equal 100%.**

Full Name (First, Middle, Last)	DOB (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)		Phone #	
Full Name (First, Middle, Last)	DOB (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)		Phone #	
Full Name (First, Middle, Last)	DOB (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)		Phone #	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.		**TOTAL:**	100%

I hereby revoke any previous designations, and I designate the person or people named on this form as Beneficiary(ies). I reserve the right to change or revoke this designation at any time.

Insured Name *(Please print)* **First name** **Middle Name** **Last Name**

Signature of Insured/Owner:

Date *(mm/dd/yyyy) (must be date form was completed*