EPIC SPECIALTY BENEFITS

The EPIC Life Insurance Company
1717 W. Broadway | P.O. Box 8430 | Madison, WI 53708-8430
800-520-5750

# Wisconsin State Employee & Annuitant Benefits+ Beneficiary Designation Form

☐ **New Employee** ☐ **Change in Beneficiary** ☐ **Other**

## General Information

Employer/Former Employer Name

| Employee Name (First, Middle Initial, Last) | Date of Birth |
|---|---|
| | |

Address
City
State
ZIP

| Marital Status: | Group Number | Customer Number |
|---|---|---|
| ☐ Single ☐ Married ☐ Domestic Partnership ☐ Divorced ☐ Widowed | | |

## Beneficiary Designation

For more space, use a separate sheet and mark the following box: ☐ ***More Beneficiaries Attached***

Please Note: *Contingent beneficiary(ies) receive payment only if all primary beneficiary(ies) are deceased or are otherwise disqualified by law. If more than one primary or contingent beneficiary is designated, payment of proceeds will be made in equal shares to the named beneficiary(ies), unless otherwise noted on this designation form.*

| Coverage | Primary Beneficiary | | % of Benefit |
|---|---|---|---|
| **Benefits+ Hospital Surgery and AD&D Benefit** | Name & Relationship<br>Last 4 digits of SSN & DOB<br>Address | | _____% |
| | Name & Relationship<br>Last 4 digits of SSN & DOB<br>Address | | _____% |
| | | | ***Total=100%*** |
| | **Contingent Beneficiary** | | |
| | Name & Relationship<br>Last 4 digits of SSN & DOB<br>Address | | _____% |
| | Name & Relationship<br>Last 4 digits of SSN & DOB<br>Address | | _____% |
| | | | ***Total=100%*** |

**Employee Signature:** _____ Date: _____

*This form replaces all prior beneficiary designations. Please mail to The EPIC Life Insurance Company, Attention: Life & Disability Department, P.O. Box 8430, Madison, WI 53708-8430 or fax to (608) 977-9861.*

## Spousal Waiver


I understand that by signing below, I am waiving my rights to the proceeds of this EPIC Life Insurance Policy. This will waive the spouse's rights to benefits.

Spousal Waiver Signature: _____ Date: _____