



P. O. Box 50434
Indianapolis, Indiana 46250
Tele #317.774.3954
FAX #317.774.3955

PARTICIPANT

Name: _____

Address: _____

City: _____ State _____ Zip Code _____

Date of Birth: _____ Social Security #: _____

BENEFICIARY DESIGNATION

PRIMARY BENEFICIARY

Individual/Trust: _____ Relationship: _____

Address: _____
(If not the same as above)

City: _____ State _____ Zip Code _____

Social Security #: _____ Date of Birth: _____

CONTINGENT BENEFICIARY

Name: _____ Relationship: _____

Address: _____

Social Security #: _____ Date of Birth: _____

Name: _____ Relationship: _____

Address: _____

Social Security #: _____ Date of Birth: _____

Name: _____ Relationship: _____

Address: _____

Social Security #: _____ Date of Birth: _____

(If you have additional contingent beneficiaries, please attach on a separate sheet)

Date

Signature of Participant

