



Beneficiary Designation

Signature(s) Required Below

Instructions:

Insured/Owner: Type or print legibly in ink. Sign and date form. Return original and retain a copy for your records.

Name of Insured/Member		Date of Birth
Group: IPSSA	Policy No. 63323-2	Social Security Number

I request that the beneficiary under this policy/certificate be changed as indicated below. Unless otherwise provided in this request, if two or more primary beneficiaries are named, the proceeds shall be paid in equal shares to the named primary beneficiaries if surviving the insured, or to the survivor or survivors. If no primary beneficiaries survive, the proceeds shall be paid in equal shares to the named contingent beneficiaries, if any. If no beneficiary survives, payment shall be made according to the terms of the policy. The right of the owner to change the beneficiary hereafter is reserved.

For each Beneficiary give Full Name, Address (*street, city, state and zip code*), Date of Birth, Social Security Number and Relationship to Insured.

Primary Beneficiaries:

Contingent Beneficiaries:

This designation is revocable as to each beneficiary except when otherwise stated, and beneficiaries of like class shall share equally with right of survivorship. The insurance company will not accept any designation using the words 'Per Stirpes.' Please refer to the Suggested Beneficiary Designations on the reverse side of this form. Any designation of an individual shall mean an individual living at the insured's death.

Dated this _____ day of _____ 20____ at _____
City, State

Signature of Owner/Insured

Signature of Irrevocable Beneficiary(ies), if any

Return to: IPSSA Management Company
P. O. Box 1617, Rocklin, CA 95677-7617

