



LONG TERM DISABILITY Beneficiary Update Form

Mail or fax completed form to: SAMBA, 11301 Old Georgetown Road, Rockville, MD 20852-2800 • (800) 638-6589 • Fax (301) 816-0191

Section 1 – Employee Information			
Last Name		First Name	Middle Initial
Address			
Street		City	State Zip
Email Address	Home Telephone		Daytime Telephone
Social Security No.	Date of Birth Month Day Year / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed

Section 2 – Beneficiary Designation for the Long Term Disability Plan

Please fill out this section so that it fully and accurately describes your request. List the full name, relationship to the employee, and date of birth of the beneficiary(ies). **If you are married, your spouse must be your beneficiary.** For the beneficiary designation to be valid, it must be delivered and recorded in the SAMBA office prior to the death of the employee.

Primary Beneficiary: The person designated to receive proceeds when they become due.

Contingent Beneficiary: (Also referred to as a secondary beneficiary.) An alternate beneficiary designated to receive proceeds if there is no eligible primary beneficiary.

PRIMARY BENEFICIARY(IES): IN EQUAL SHARES OR AS DESIGNATED BELOW

Full Name and Address	% of Proceeds	Relationship to Employee	Date of Birth
			/ /
			/ /
			/ /

TOTAL 100%

as shall then be living, and if no such beneficiary is then living

CONTINGENT BENEFICIARY(IES): IN EQUAL SHARES OR AS DESIGNATED BELOW

Full Name and Address	% of Proceeds	Relationship to Employee	Date of Birth
			/ /
			/ /
			/ /

TOTAL 100%

✓

Employee's Signature Date