



Notice: It is the employee's responsibility to notify the Human Resources office in order to change their beneficiary information. BRMC will not be responsible for any info other than that which is provided by said employee.

Employee Life Insurance Beneficiary Form

Full Name:	Current Date:
Mailing Address:	Hire Date:
	Supervisor:
Phone #: _____	Social Security # _____-____-_____
Cell #: _____	Marital Status:
Job Title:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Beneficiary Contact Information: <input type="checkbox"/> Primary Name: _____ Mailing Address: _____ Relationship: _____	Home Phone # (____)_____-_____ Cell Phone # (____)_____-_____
Beneficiary Contact Information: <input type="checkbox"/> Primary <input type="checkbox"/> Secondary Name: _____ Mailing Address: _____ Relationship: _____	Home Phone # (____)_____-_____ Cell Phone # (____)_____-_____
Beneficiary Contact Information: <input type="checkbox"/> Primary <input type="checkbox"/> Secondary Name: _____ Mailing Address: _____ Relationship: _____	Home Phone # (____)_____-_____ Cell Phone # (____)_____-_____

Employee Signature: _____ **Date:** _____