



**CITY OF CHELSEA, MA**  
**Human Resources Department**

City Hall, 500 Broadway, Room 301 · Chelsea, MA 02150  
 Phone: 617.466.4170 · Fax: 617.466.4175



**Life Insurance Beneficiary Form**

Employer <b>CITY OF CHELSEA</b>	Department City <input type="checkbox"/> School <input type="checkbox"/>	Group Number <b>26213</b>
Employee Name (Print)		Social Security Number
Mailing Address (Street, City, State, Zip)		Date of Birth (mm/dd/yyyy)

**Primary Beneficiaries** (Person or persons who will receive the life insurance proceeds upon your death.)

Name	Social Security Number	Date of Birth (mm/dd/yyyy)
Mailing Address (Street, City, State, Zip)	Relationship to Insured	% Paid to Beneficiary
Name	Social Security Number	Date of Birth (mm/dd/yyyy)
Mailing Address (Street, City, State, Zip)	Relationship to Insured	% Paid to Beneficiary
Name	Social Security Number	Date of Birth (mm/dd/yyyy)
Mailing Address (Street, City, State, Zip)	Relationship to Insured	% Paid to Beneficiary
The total percentage of all Primary beneficiaries should add up to 100%. If no percentages are indicated, the proceeds will be divided equally. If no Primary beneficiary survives, proceeds will be paid to the Contingent beneficiaries listed below.		

**Contingent Beneficiaries** (Person or persons who will receive the life insurance proceeds if there is no surviving primary beneficiary.)

Name	Social Security Number	Date of Birth (mm/dd/yyyy)
Mailing Address (Street, City, State, Zip)	Relationship to Insured	% Paid to Beneficiary
Name	Social Security Number	Date of Birth (mm/dd/yyyy)
Mailing Address (Street, City, State, Zip)	Relationship to Insured	% Paid to Beneficiary
Name	Social Security Number	Date of Birth (mm/dd/yyyy)
Mailing Address (Street, City, State, Zip)	Relationship to Insured	% Paid to Beneficiary

**Signatures**

Employee Signature	Date Signed (mm/dd/yyyy)
Employer/Administrator Signature	Title
	Date Signed (mm/dd/yyyy)