Broward Health®

Employee Name: _____

Employee #: _____ Date: _____

BROWARD HEALTH BENEFICIARY DESIGNATION FORM

General Instructions and Information:

Instructions:

1. Please use the full names of all beneficiaries. For example, if the employee is John Doe, and he wishes to designate his wife as a beneficiary, he should indicate Mary A. Doe, not Mrs. John Doe.
2. If more space is required for your beneficiaries, please use additional paper, and attach it to this form.

Information:

1. A primary beneficiary is entitled to receive payment only if he or she is alive when payment is due.
2. A contingent beneficiary is entitled to receive payment only if he or she is alive when payment is due and only if there is no primary beneficiary alive. It is not necessary to designate a contingent beneficiary.
3. Minor child(ren) cannot collect life insurance or pension benefits without a court appointed guardian.

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Primary Beneficiary Name	Percentage	Date of Birth	Address	Relationship
Contingent Beneficiary Name				

SUPPLEMENTAL TERM LIFE INSURANCE

Primary Beneficiary Name	Percentage	Date of Birth	Address	Relationship
Contingent Beneficiary Name				

CASH BALANCE PENSION PLAN

Primary Beneficiary Name	Percentage	Date of Birth	Address	Relationship
Contingent Beneficiary Name				

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NOTE:
Beneficiary changes become effective on the date this form is signed by the employee/retiree. If you are currently participating in the Star Plus 403(b)/457(b) plans with COREBRIDGE FINANCIAL and wish to change that beneficiary, please contact COREBRIDGE FINANCIAL at 1.800.448.2542.

BUSINESS TRAVEL ACCIDENT INSURANCE

Primary Beneficiary Name	Percentage	Date of Birth	Address	Relationship
Contingent Beneficiary Name				

ACCIDENT INSURANCE PLAN

Primary Beneficiary Name	Percentage	Date of Birth	Address	Relationship
Contingent Beneficiary Name				

CRITICAL CARE INSURANCE PLAN

Primary Beneficiary Name	Percentage	Date of Birth	Address	Relationship
Contingent Beneficiary Name				

HOSPITAL INDEMNITY INSURANCE PLAN

Primary Beneficiary Name	Percentage	Date of Birth	Address	Relationship
Contingent Beneficiary Name				

Employee Signature Date

Employee Name – Print

Employee #

HR Rep Signature Date

HR Rep Title