INSURANCE MANAGEMENT SERVICES
P.O. Box 15688 • Amarillo, TX 79105
Email to Eligibility.Fax@imsm.net using IMS Secure Email
Or
Fax to: (806) 373-1136

Beneficiary Designation Form

Employer:_____

Group / Division:_____

Employee Information:

Name:_____

SSN:_____

Beneficiary Information:

Name:_____ Relation:_____

Birth Date:_____ SSN:_____ Percentage:_____

Name:_____ Relation:_____

Birth Date:_____ SSN:_____ Percentage:_____

Name:_____ Relation:_____

Birth Date:_____ SSN:_____ Percentage:_____

Name:_____ Relation:_____

Birth Date:_____ SSN:_____ Percentage:_____

Contingent Beneficiary Information:

Name:_____ Relation:_____

Birth Date:_____ SSN:_____ Percentage:_____

Name:_____ Relation:_____

Birth Date:_____ SSN:_____ Percentage:_____

Name:_____ Relation:_____

Birth Date:_____ SSN:_____ Percentage:_____

Name:_____ Relation:_____

Birth Date:_____ SSN:_____ Percentage:_____

Comments (optional):

Enter comments below to clarify the distribution of benefits among Beneficiaries.

_____

Authorization:

I hereby revoke any previous beneficiary designation and am now changing my beneficiary to the person(s) shown above.

_____ _____

Signature Date