



Oneida Beneficiary Designation Form INSTRUCTIONS



To ensure your life insurance proceeds are paid out the way you want, complete the following:

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Section A. Member Information – Required

- Full Legal Name - Your name must match the name on file with the Enrollment Department.
- Date of Birth
- Enrollment Number (If Known)
- Full Mailing Address
- Marital Status
 - If you are INFORMALLY SEPARATED, you must check MARRIED.
 - If you are LEGALLY SEPARATED, attach a copy of the court document.

Section B. Primary Beneficiary(ies) – Optional including the CHECK BOX for Enrollments, however if you choose to list Primary Beneficiary(ies), the following information is Required:

- Full Legal Name
- Address
- Date of Birth
- Relationship
- % of Benefit (Example: 20%, 50%, 100%, etc.)

Section C. Spousal Waiver

If you are Single, Divorced, or Widowed	If you are Married (Including Separated)
SKIP THIS SECTION	REQUIRED if you are married AND you designated a primary beneficiary(ies) other than your spouse and/or checked the box in Section B.

Section D. Member Signature and Date

Sign and date the form – Your name must match the name on file with the Enrollment Department.

- Check the box below your signature if you require future forms to reflect a notary seal

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Section E. Member Information – Required if completing Section F.

- Full Legal Name
- Date of Birth
- Enrollment Number (If Known)

Section F. Contingent Beneficiary(ies) – Optional, however if you choose to list Contingent Beneficiary(ies), the following information is Required:

- Full Legal Name
- Address
- Date of Birth
- Relationship
- % of Benefit (Example: 20%, 50%, 100%, etc.)

Section G. Member Signature and Date – Required if completing Section F.

Sign and date the form – Your name must match the name on file with the Enrollment Department.

PLEASE KEEP YOUR BENEFICIARY DESIGNATIONS UP TO DATE.

You should review your beneficiary designations at least once a year to ensure they are accurate. Here are some good reasons to update your beneficiary designations:

- You get married.
- You have a child.
- You get divorced.
- Your current beneficiary dies.
- It's been some time since you've updated your beneficiary designations.

For complete policy information, Term Life Certificate/Endorsement and Schedule of Benefits, visit our website indicated below.

Oneida Enrollment Department | PO Box 365, Oneida WI 54155-0365
 Phone: 920-869-6200 | Toll-Free: 800-571-9902 | Fax: 920-869-2995
 enrollments@oneidation.org | www.oneidation.org/enrollment/

Oneida Beneficiary Designation Form EXAMPLE



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Oneida Beneficiary Designation Form

Section A: Member Information – Please Print

First Name <i>John</i>	MI	Last Name <i>Doe Sr.</i>	Date of Birth <i>MM/DD/YYYY</i>	Enrollment Number <i>XXXXX</i>
Address <i>123 Main St</i>		City <i>Any Town</i>	State <i>WI</i>	Zip <i>XXXXX</i>
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated (copy of court document attached) <input checked="" type="checkbox"/> Married – Spouse's Name: <i>Jane Doe</i>				

Section B: Primary Beneficiary(ies)

I designate the person(s) named in Section B as my Primary Beneficiary(ies) to receive payment under the policy. The share of any Primary Beneficiary who is no longer living or is otherwise disqualified by law at the time of my death, will pass to any remaining Primary Beneficiary(ies) listed below or, if there are no surviving Primary Beneficiaries, then to any surviving Contingent Beneficiaries listed on page 2 or, finally, the Naming Sequence as outlined in the Term Life Certificate. For more space, use a separate sheet and mark the following box: More Primary Beneficiaries Attached.

I authorize the Enrollment Department to request payment of my funeral expenses. **If I am married,** I understand Section C: Spousal Waiver must be signed and dated for this request to be valid. Any remaining funds will be disbursed to my Beneficiary(ies) listed in section B or F.

Full Name (First, MI, Last)	Address (street, city, state, zip)	Date of Birth	Relationship	% of Benefit
<i>Jane A. Doe</i>	<i>123 Main St, Any Town WI XXXXX</i>	<i>MM/DD/YYYY</i>	<i>Wife</i>	<i>50</i>
<i>Daniel D. Doe</i>	<i>987 Main St, Any Town WI XXXXX</i>	<i>MM/DD/YYYY</i>	<i>Brother</i>	<i>50</i>
The amounts listed in the "% of Benefit" column MUST EQUAL				100%

Section C: Spousal Waiver – REQUIRED if you are married AND you designate a primary beneficiary(ies) other than your spouse and/or checked the box in Section B.
By signing below, I am authorizing EPIC Life Insurance Company to release a portion or all of the Oneida Life Insurance benefit to the designated beneficiary(ies) listed in Sections B or F as outlined in the Term Life Certificate.

Spousal Signature: *Jane A. Doe* Date: *MM/DD/YYYY*

Section D: Member Signature and Date – This form replaces all prior beneficiary designation forms.
By signing below, I authorize the Oneida Enrollment Department, to release the information provided on this form to my named beneficiary(ies) and/or the funeral home(s) handling my funeral arrangements upon my death.

Member Signature: *John Doe Sr.* Date: *MM/DD/YYYY*

Check here if all future forms must be Notarized (Notarized forms cannot be faxed or scanned)

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CHECK BOX is OPTIONAL
This authorizes the Enrollment Dept. to request payment for your funeral expenses

Section B is OPTIONAL. If you list primary beneficiaries all fields are required

If you are **MARRIED** Section C is **REQUIRED**

Section A is REQUIRED

Percentages must equal 100% combined

Section D is REQUIRED



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ONEIDA BENEFICIARY DESIGNATION FORM PAGE 2

Only complete Page 2 if listing Contingent Beneficiaries
If listing Contingent Beneficiaries, all Sections on Page 2 are Required
Primary Beneficiaries CANNOT be named as Contingent Beneficiaries

Section E: Member Information – Please Print

First Name <i>John</i>	MI	Last Name <i>Doe</i>	Date of Birth <i>MM/DD/YYYY</i>	Enrollment Number <i>XXXXX</i>
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Section F: Contingent Beneficiary(ies)

I designate the person(s) named in Section F as my Contingent Beneficiary(ies) to receive payment under the policy only if all Primary Beneficiary(ies) are deceased or are otherwise disqualified by law. For more space, use a separate sheet and mark the following box: More Contingent Beneficiaries Attached.

Full Name (First, MI, Last)	Address (street, city, state, zip)	Date of Birth	Relationship	% of Benefit
<i>John Doe Jr.</i>	<i>456 Main St, Any Town WI XXXXX</i>	<i>MM/DD/YYYY</i>	<i>Son</i>	<i>50</i>
<i>Mary B. Doe</i>	<i>789 Main St, Any Town WI XXXXX</i>	<i>MM/DD/YYYY</i>	<i>Granddaughter</i>	<i>50</i>
The amounts listed in the "% of Benefit" column MUST EQUAL				100%

Section G: Member Signature and Date

Member Signature: *John Doe Sr.* Date: *MM/DD/YYYY*

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Section F is OPTIONAL. If you list contingent beneficiaries all fields are required

Section G is REQUIRED if you list contingent beneficiaries

Section E is REQUIRED if you list contingent beneficiaries

Percentages must equal 100% combined



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Oneida Beneficiary Designation Form

Section A: Member Information – Please Print				
First Name	MI	Last Name	Date of Birth	Enrollment Number
Address			City	State Zip
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated (copy of court document attached) <input type="checkbox"/> Married – Spouse’s Name:				

Section B: Primary Beneficiary(ies)				
I designate the person(s) named in Section B as my Primary Beneficiary(ies) to receive payment under the policy. The share of any Primary Beneficiary who is no longer living or is otherwise disqualified by law at the time of my death, will pass to any remaining Primary Beneficiary(ies) listed below or, if there are no surviving Primary Beneficiaries, then to any surviving Contingent Beneficiaries listed on page 2 or, finally, the Naming Sequence as outlined in the Term Life Certificate. For more space, use a separate sheet and mark the following box: <input type="checkbox"/> More Primary Beneficiaries Attached.				
<input type="checkbox"/> I authorize the Enrollment Department to request payment of my funeral expenses. If I am married , I understand Section C: Spousal Waiver must be signed and dated for this request to be valid. Any remaining funds will be disbursed to my Beneficiary(ies) listed in section B or F.				
Full Name (First, MI, Last)	Address (street, city, state, zip)	Date of Birth	Relationship	% of Benefit
The amounts listed in the “% of Benefit” column MUST EQUAL				100%

Section C: Spousal Waiver – REQUIRED if you are married AND you designate a primary beneficiary(ies) other than your spouse and/or checked the box in Section B.	
By signing below, I am authorizing EPIC Life Insurance Company to release a portion or all of the Oneida Life Insurance benefit to the designated beneficiary(ies) listed in Sections B or F as outlined in the Term Life Certificate.	
Spousal Signature:	Date:

Section D: Member Signature and Date – This form replaces all prior beneficiary designation forms.	
By signing below, I authorize the Oneida Enrollment Department, to release the information provided on this form to my named beneficiary(ies) and/or the funeral home(s) handling my funeral arrangements upon my death.	
Member Signature: _____	Date: _____
<input type="checkbox"/> Check here if all future forms must be Notarized (Notarized forms cannot be faxed or scanned)	



ONEIDA BENEFICIARY DESIGNATION FORM PAGE 2

**Only complete Page 2 if listing Contingent Beneficiaries.
If listing Contingent Beneficiaries, all Sections on Page 2 are Required.
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First Name	MI	Last Name	Date of Birth	Enrollment Number
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I designate the person(s) named in Section F as my Contingent Beneficiary(ies) to receive payment under the policy only if all Primary Beneficiary(ies) are deceased or are otherwise disqualified by law. For more space, use a separate sheet and mark the following box: **More Contingent Beneficiaries Attached.**

Full Name (First, MI, Last)	Address (street, city, state, zip)	Date of Birth	Relationship	% of Benefit
The amounts listed in the “% of Benefit” column MUST EQUAL				100%

Section G: Member Signature and Date

Member Signature: _____ Date: _____