Oneida Life Insurance Plan Plus
Death Benefit Designation Beneficiary Form

Oneida Beneficiary Designation Form

Section A: Member Information – Please Print

First Name	MI	Last Name		Date of Birth	Enrollment Number
Address			City	State	Zip	Phone Number

Section B: Primary Beneficiary(ies)

The Oneida Trust Enrollment Department will request payment for my funeral expenses. Any remaining funds will be disbursed to my Beneficiary(ies) listed in section B or E.

I designate the person(s) named in Section B as my Primary Beneficiary(ies) to receive the remainder payment under the program. The share of the 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 not surviving Primary Beneficiaries, then to any surviving Contingent Beneficiary(ies) listed on page2. ❑ **More Primary Beneficiaries Attached.**

Full Name (First, MI, Last)	Address (street, city, state, zip)	Date of Birth	Relationship	Phone Number	% of Benefit

The amounts listed in the "% of Benefit" column MUST EQUAL **100%**

Section C: Member Signature and Date – This form replaces all prior beneficiary designation forms.

By signing below, I authorize the Oneida Trust 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: _____

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Oneida Nation
Trust Enrollments Department

ONEIDA

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

Section D: Member Information-Please Print

First Name/MI/Last Name	Date of Birth	Enrollment Number

Section E: Contingent Beneficiary(ies)

I designate the person(s) named in Section E as my Contingent Beneficiary(ies) to receive payment under the program 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	Phone Number	% of Benefit
The amounts listed in the "% of Benefit" column MUST EQUAL					**100%**

Section F: Member Signature and Date

Member Signature: _____ Date: _____

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