Oneida Beneficiary Designation Form (Minor)

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. Listed beneficiaries have 1 year from date of death to claim. ❑ **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, we authorize the Oneida Trust Enrollment Department, to release the information provided on this form to the named beneficiary(ies) and/or the funeral home(s) handling the funeral arrangements upon the death of the minor child.

Parent(s) or Guardian(s) signature: _____Date: _____

Parent(s) or Guardian(s) signature: _____Date: _____

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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

Parent(s) or Guardian(s) signature: _____ Date: _____

Parent(s) or Guardian(s) signature:_____ Date: _____

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