Accident & Health Beneficiary Designation Form

Please complete this form and return it to your organization's Secretary who should maintain this form with your emergency service organization's records. Please do not return this form to Provident. If necessary, please photocopy this page or print additional copies at www.providentbenefits.com.
Please PRINT or TYPE.

Policyholder Name (Emergency Service Organization) _____ Policy # _____

Insured Person's Last Name _____ First _____ Initial _____ Date of Birth _____

Insured Person's Street Address _____

Insured Person's City _____ State _____ Zip Code _____ Social Security # _____

Primary Beneficiary ~ If the benefit is to be paid to more than one person, please list the names, dates of birth, and Social Security #'s, and indicate the relationship to the Insured Person, as well as the percentage each primary beneficiary should receive. If percentage shares are not given, they will be equal. Total percentage for all primary beneficiaries must equal 100%.

Name	Date of Birth	Social Security #	Relationship	% Share

Contingent Beneficiary ~ The contingent beneficiary(ies) will only receive benefits if all named primary beneficiaries predecease the Insured Person. If the benefit is to be paid to more than one contingent beneficiary, please list the names, dates of birth, and Social Security #'s, and indicate the relationship to the Insured Person, as well as the percentage each contingent beneficiary should receive. If percentage shares are not given, they will be equal. Total percentage for all contingent beneficiaries must equal 100%.

Name	Date of Birth	Social Security #	Relationship	% Share

Insured Person's Signature _____ Date Signed _____

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Provided by: Provident Agency, Inc.
Toll Free 800.447.0360

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