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DESIGNATION OF BENEFICIARY

District of Columbia Employees Group Life Insurance

WARNING
Read instructions on back of duplicate before filling in this form

INFORMATION CONCERNING THE INSURED:

Name *(Last, First, Middle)*	Date of Birth (Month, Day, Year)	Social Security Number

Place an "X" in the appropriate box below:

☐ An Employee	☐ Retired or applicant for retirement	☐ Receiving Disability Compensation benefits or an applicant for Disability Compensation benefits

If you are retired or receiving Disability Compensation, give your claim number.

Department or agency in which presently employed *(If retired or on Disability Compensation, former department or agency):*

Department or Agency	Bureau	Division

I, the individual identified above, canceling any and all previous Designations of Beneficiary under the District of Columbia Employees Group Life Insurance Program heretofore made by me, do now designate the beneficiary or beneficiaries named below to receive any amount of LIFE INSURANCE and ACCIDENTAL DEATH INSURANCE due and payable at my death.
I understand that this Designation of Beneficiary will remain in full force and effect, with respect to any amount payable, unless or until canceled by me in writing, or until such time as it is automatically canceled (see regulation "f" on reverse side of duplicate copy). If this designation form is determined invalid for any reason, the next prior valid designation form will be given full force and effect. If no such prior form exists, the proceeds will be distributed according to the Order of Precedence.

INFORMATION CONCERNING THE BENEFICIARY OR BENEFICIARIES *(See Examples of Designations):*

Type or Print First Name, Middle Initial, and Last Name of Each Beneficiary	Type or Print Address *(Including ZIP Code)* of Each Beneficiary	Relationship	Share to Be Paid to Each Beneficiary
Social Security No. (if available) / Birthdate (if available)			
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For each type of insurance (Basic Life, Option A—Standard, and Option B—Additional): (1) I hereby direct, unless otherwise indicated above, that if more than one beneficiary is named, the share of any beneficiary who may predecease me or become disqualified for any reason from receiving a share of the benefits shall be distributed equally among the surviving beneficiaries, or entirely to the survivor; (2) I understand that this Designation of Beneficiary shall be void if none of the designated beneficiaries is living at the time of my death.

I hereby specifically reserve the right to cancel or change this designation of beneficiary at ant time without knowledge or consent of the beneficiary.

PRINT OR TYPE NAME AND ADDRESS (Including ZIP Code) OF INSURED	Please check:
	☐ I have signed this form in the presence of the **two** witnesses who have signed below.
	☐ Neither witness is named as a beneficiary.
	☐ If I designated shares to be paid to more than one beneficiary, the shares add up to 100%. (Dollar amounts are not acceptable.)
Date of Execution *(Month, Day, Year)*	Signature of Insured

WITNESSES TO SIGNATURE *(A witness is ineligible to receive payment as a beneficiary):*

Signature of Witness	Number and Street	City, State and ZIP Code
Signature of Witness	Number and Street	City, State and ZIP Code

Receiving Agency	Date of Receipt	Agency Signature	Title

SEE REVERSE SIDE OF DUPLICATE COPY FOR INSTRUCTIONS ON WHERE TO FILE THESE FORMS.

This Designation of Beneficiary Form is to be used solely for the disposition of proceeds of insurance under the District of Columbia Employees Group Life Insurance Program.

Order of Precedence

If, at the death of the insured, there is no designated beneficiary entitled to all or any part of the insurance, the amount of insurance for which there is no designated beneficiary shall be payable to the person or persons listed below surviving at the date of the insured's death, in the following order of precedence:

1. To the widow or widower.
2. If neither of the above, to the child or children, with the share of any deceased child distributed among the descendants of that child.
3. If none of the above, to the parents in equal shares or the entire amount to the surviving parent.
4. If none of the above, to the executor or administrator of the estate.
5. If none of the above, to the other next of kin who are entitled under the laws of the domicile of the insured at the date of death.

IT IS NOT NECESSARY FOR THE INSURED TO DESIGNATE A BENEFICIARY UNLESS HE OR SHE WISHES PAYMENT TO BE MADE IN A WAY OTHER THAN THE ORDER OF PRECEDENCE SHOWN ABOVE.

Regulations

(a) The Designation of Beneficiary shall be in writing, signed and witnessed by two people, and received in the appropriate Servicing Personnel Office or retirement office prior to the death of the designator.

(b) A change or cancellation of beneficiary in a last will or testament, or in any other document not witnessed and filed as required by these regulations, shall not have any force or effect.

(c) A witness to a Designation of Beneficiary is ineligible to receive payment as a beneficiary.

(d) Any person, firm, corporation or legal entity (except an agency of the Federal or District of Columbia Governments) may be named as beneficiary.

(e) A change of beneficiary may be made at any time and without the knowledge or consent of the previous beneficiary, and this right cannot be waived or restricted.

(f) A Designation of Beneficiary is automatically canceled 31 days after the employee stops being insured.

(g) If an insured person provides in a valid designation of beneficiary that a designated beneficiary shall be entitled to the proceeds of the insurance only if the beneficiary survives him/her for a period of time (not more than 30 days) as specified by the designator, no right to the insurance shall vest as to such beneficiary during that period. In the event such beneficiary does not survive the specified period, payment of the proceeds of the insurance will be made as if the beneficiary had predeceased the insured.

Instructions

1. The examples printed on the back of the first page of this form may be helpful to you in filling out this form to name a beneficiary or to cancel a prior Designation of Beneficiary. More than one beneficiary can be designated. Unless you direct otherwise in the Designation, the person(s) named will be considered as beneficiary (or beneficiaries) for *(both)* Basic Life and optional coverages. The total insurance can be divided by showing what share is to be paid to each beneficiary (example 2), or different beneficiaries may be designated for Basic Life and optional coverages (example 4).
2. Complete this form in duplicate. All entries on the form except signatures should be typed or printed in ink (typewriting preferred). Signatures must be in ink.
3. It is recommended, but not necessary, to file a new Designation of Beneficiary when the name or address of the insured or the beneficiary is changed.
4. *This form must be free of erasures or alterations.*

Important: If you wish to designate a trust as beneficiary, ask your employing office for instructions.

Where to File Completed Form

If insured as an employee, file the form with the Servicing Personnel Office for the agency in which employed. If insured as a retired police officer, firefighter or teacher file the form with the Office of Pay and Retirement, Retirement Division, 410 E Street, NW, Washington D.C. 20001. Other retired employees should file the form with the D.C. Office of Personnel, Benefits Administration Division, 613 G Street, NW, Washington D.C. 20001. Persons receiving D.C. Disability Compensation should file the form with the Servicing Personnel Office for the last agency where they worked. If application for retirement or compensation is pending, file the form with the Servicing Personnel Office for the agency in which employed. The duplicate will be noted and returned as evidence that the original has been received and filed.

Privacy Act Statement

All official personnel records of the District government shall be established, maintained and disposed of in a manner designed to ensure the greatest degree of applicant or employee privacy while providing adequate, necessary and complete information for the District to carry out its responsibilities under this chapter. Such records shall be established, maintained and disposed of in accordance with rules and regulations issued by the Mayor. (D.C. Code sec. 1-632.1 *et seq.*) The data you furnish will be used to determine the beneficiary(ies) for your life insurance and accidental death insurance. This information will be shared with the insurance company providing benefits in the event of your death. It will also be shared with the D.C. Office of Personnel and be placed in your Official Personnel Folder. This information may be shared with District or federal agencies or congressional offices which have a need to know it in connection with your application for a job, license, grant or other benefit. It may also be shared with national, state, local or other charitable or social security administrative agencies to determine and issue benefits under their programs. In addition, to the extent this information indicates a possible violation of civil or criminal law, it may be shared with appropriate federal, state or local law enforcement agencies. While the law does not require you to supply all the information requested on this form, it may not be possible to process your Designation of Beneficiary if you fail to do so.

Designations should be kept current. With changes in family status (marriage, divorce, death, births, etc.) you may wish to make changes in designations. Keep this form in a safe place.