State of Oklahoma
Employees Group Insurance Division
Outstanding Disability Benefits Beneficiary Designation

If you receive disability benefits through the HealthChoice Disability Plan, you have the option to designate a beneficiary to receive your final disability benefit in the event of your death.

If you elect to name a beneficiary, you must complete the "Outstanding Disability Benefits Beneficiary Designation" form at the time you complete your disability application. If you want to change your beneficiary at some point in the future, it is your responsibility to complete and submit a new beneficiary form to the disability claims administrator. For example, if you name your spouse and are later divorced, you may want to complete a new form.

Primary Beneficiary: Receives priority distribution upon your death.
Contingent Beneficiary: Receives distribution **only** if the primary beneficiary(ies) are deceased at the time of your death.

If you do not elect to name a beneficiary, the disability claims administrator will issue your final disability benefit to your estate. Please be advised that access to the funds paid to an estate may be delayed due to the probate process.

Instructions:

1. Complete and **sign** the Outstanding Disability Benefits Beneficiary Designation form.

2. Return the form to the disability claims administrator and keep a copy for your records.

   Sedgwick
   P.O. Box 14648
   Lexington, KY 40512-4648

Please keep all beneficiary information current.

Employees Group Insurance Division
Outstanding Disability Benefits Beneficiary Designation Form

Please read the instructions carefully and complete this form in ink.

SSN or Member ID: _____ Member Name: _____
First MI Last

Address: _____
☐ New Address Street City State ZIP

Phone: (____) _____ Alt Phone: (____) _____

****Important**: Please ensure the "Share Percentage" section in both Primary Beneficiary(ies) and Contingent Beneficiary(ies) add up to 100 percent. Payment will be made in equal shares to all surviving beneficiaries unless otherwise indicated.**

PRIMARY BENEFICIARY(IES)

Primary Beneficiary's Name and Address	SSN	Phone #	Relationship	Date of Birth	Share Percentage
					100%

CONTINGENT BENEFICIARY(IES)

Proceeds are paid to the contingent beneficiary(ies) identified below only if there is no surviving primary beneficiary(ies).

Contingent Beneficiary's Name and Address	SSN	Phone #	Relationship	Date of Birth	Share Percentage
					100%

I have named the above beneficiary or beneficiaries to receive my disability insurance benefits. I understand this form replaces and cancels all prior beneficiary designations and will become effective only when it is received by the disability claims administrator.

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_____ _____

Member Signature - original signature required Date

Mail this form to Sedgwick at P.O. Box 14648, Lexington, KY 40512-4648