INTERNATIONAL MONETARY FUND
WASHINGTON, D.C. 20431

**GROUP LIFE INSURANCE**

**DESIGNATION OF BENEFICIARY(IES)**

**INSTRUCTIONS TO PARTICIPANT:**

1. *Please complete and return form to the Insurance Team, Employment, Compensation & Benefits Division, Room No. HQ2-5-009*
2. *Do not erase or attempt to make any corrections on the signed form.*
3. *Kindly, ensure that your beneficiaries are updated when a change is deemed necessary.*

**Participant's Information**

| | | | | | |
|---|---|---|---|---|---|
| Name of Participant | . | | | . | |
| | First | | | Last | M.I. |
| Home Address | . | . | | . | |
| | Street | City | State | Zip | Country |
| E-mail Address | . | Telephone Number | . | Social Security # or Staff ID # | . |

**BENEFICIARY DESIGNATION**

I revoke all previous beneficiary designation and designate the beneficiary(ies) listed below as beneficiary(ies) of all insurance provided under such policy. I reserve the right to make future changes subject to policy provisions.

**Primary Beneficiary Designation**

| Full Name (Last, First) | Relationship | Date of Birth | Contact Info. | Address (Street, City, State, Zip, & Country) | Share % |
|---|---|---|---|---|---|
| . | . | . | . | | |
| . | . | . | . | . | |
| | | / / | | | |
| | | / / | | | |
| | | / / | | | |

| Trust Name | Contact Name | Date of Trust | Address (Street, City, State, Zip, & Country) | Share % |
|---|---|---|---|---|
| | | / / | | |
| | | / / | | |

| Estate Owner's Name | Contact No. | Address (Street, City, State, Zip, & Country) | Share % |
|---|---|---|---|
| | | | |

Payments will be made in equal shares or all to the survivor, unless otherwise indicated. Total 100%

**GROUP LIFE INSURANCE**

**DESIGNATION OF BENEFICIARY(IES)**

**BENEFICIARY DESIGNATION (CONTINUED...)**
In the event said primary beneficiary(ies) predecease(s) the insured, I designate as contingent beneficiary(ies)

## Contingent Beneficiary Designation

| Full Na me (Last, First) | Relationship | Date of Birth | Contact Info. | Address (Street, City, State, Zip, & Country) | Share % |
|---|---|---|---|---|---|
| Enter Text here | | MM/DD/YYYY) | | | |
| | | . | | | |
| | | . | | | |
| | | . | | | |
| | | . | | | |

| Trust Name | Contact Information | Date of Trust | Address (Street, City, State, Zip, & Country) | Share % |
|---|---|---|---|---|
| | | . | | |
| | | . | | |

| Owner Name | Contact Info. | Address (Street, City, State, Zip, & Country) | Share % |
|---|---|---|---|
| | | | |

Payments will be made in equal shares or all to the survivor, unless otherwise indicated. Total 100%

| | |
|---|---|
| | . |
| Signature of Participant | Date: |

**FOR USE BY HUMAN RESOURCES DEPARTMENT ONLY**

1. Effective Date of this action

Date: .

2. This application has been reviewed and the applicant is certified to be eligible for the type of action indicated.

Certifying Officer: Date: .