



GROUP INSURANCE BENEFICIARY CARD

Please Complete, Sign and Mail to: Organization of Staff Analysts Welfare Fund
220 East 23rd Street - Suite 707 - New York NY - 10010

Employee/Retiree's Name	<input type="checkbox"/> Married	Gender:
Last Name:	<input type="checkbox"/> Single	Date of Birth:
First Name:	<input type="checkbox"/> Widowed	
Middle Name:	<input type="checkbox"/> Divorced	
Home Address (No & Street):	City/State:	Home Phone:
Email:	Zip:	Cell Phone:

Beneficiary #1		<input type="checkbox"/> Primary Beneficiary	Beneficiary #2 (if any)		<input type="checkbox"/> Primary Beneficiary
Full Name		<input type="checkbox"/> Contingent Beneficiary	Full Name		<input type="checkbox"/> Contingent Beneficiary
Street Address			City/State/Zip		
Street Address			City/State/Zip		
Social Security Number	Benefit Percentage		Social Security Number	Benefit Percentage	
	%			%	
Birth Date (mo/day/yr)			Birth Date (mo/day/yr)		
Beneficiary Phone No.:	Email		Beneficiary Phone No.:	Email	

DATE	SOCIAL SECURITY NUMBER	EMPLOYEE/RETIREE SIGNATURE (Do Not Print)
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We require an original signature on this form. Please mail it back to the address at the top.

Please note: If any of the information above is missing, this form will be returned to you for completion.

Please retain a copy for your records.

Need space for additional beneficiaries? Please use the boxes on the back of this form.

Beneficiary #3 (if any) Full Name		<input type="checkbox"/> Primary Beneficiary <input type="checkbox"/> Contingent Beneficiary <input type="checkbox"/> Secondary Contingent Beneficiary		Beneficiary #4 (if any) Full Name		<input type="checkbox"/> Primary Beneficiary <input type="checkbox"/> Contingent Beneficiary <input type="checkbox"/> Secondary Contingent Beneficiary	
Street Address		City/State/Zip		Street Address		City/State/Zip	
Social Security Number		Benefit Percentage		Social Security Number		Benefit Percentage	
		%				%	
Birth Date(mo/day/yr)				Birth Date (mo/day/yr)			
Beneficiary Phone No.		Email		Beneficiary Phone No.		Email	

Beneficiary #5 (if any) Full Name		<input type="checkbox"/> Primary Beneficiary <input type="checkbox"/> Contingent Beneficiary <input type="checkbox"/> Secondary Contingent Beneficiary		Beneficiary #6 (if any) Full Name		<input type="checkbox"/> Primary Beneficiary <input type="checkbox"/> Contingent Beneficiary <input type="checkbox"/> Secondary Contingent Beneficiary	
Street Address		City/State/Zip		Street Address		City/State/Zip	
Social Security Number		Benefit Percentage		Social Security Number		Benefit Percentage	
		%				%	
Birth Date (mo/day/yr)				Birth Date (mo/day/yr)			
Beneficiary Phone No.		Email		Beneficiary Phone No.		Email	