



Human Resources

EPISD CHANGE OF BENEFICIARY FORM

PLEASE PRINT CLEARLY

Employee Last Name, First Name

Social Security Number

Address

City, State, Zip Code

School Campus/Location

I am requesting that the designation of my beneficiary(ies) for life insurance coverage and/or any voluntary coverage, if applicable, and for my last check be changed to the following individual(s):

Beneficiary Full Name (first and last)	SS#	DOB	Relationship	Address (city, state, zip)

Employee Signature

BEFORE ME, on this day personally appeared _____ known to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that this person executed the same for the purpose and consideration therein expressed.

GIVEN under my hand and official seal this the _____ day of _____, _____
(Month) (Year)

(SEAL)

Signature of Notary Public County State