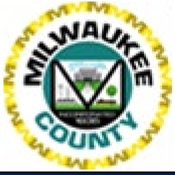

# *Department of Human Resources*

Division of Employee Benefits

## Milwaukee County Retiree Group Life – Beneficiary Change Form

Use to DECLINE, CANCEL OR CHANGE BENEFICIARY

### Retiree Information

| **Name** | **Social Security Number** | |
|---|---|---|
| **Address** | **Phone Number** | **Birth Date** |

### Reason for Application

☐ **Waive / Cancel Coverage**

☐ **Change of Beneficiary** (I designate the following as beneficiary or beneficiaries**)**

| Name | Date of Birth | Relationship | Share (%) | Beneficiary Type | Address |
|---|---|---|---|---|---|
| | | | | ☐Primary or ☐Contingent | |
| | | | | ☐Primary or ☐Contingent | |
| | | | | ☐Primary or ☐Contingent | |
| | | | | ☐Primary or ☐Contingent | |
| | | | | ☐Primary or ☐Contingent | |

I am confirming that all information is represented accurately, and that dependent/s listed on my record are eligible for coverage under the terms of Milwaukee County's benefit plans. I understand I may be required to provide verification of all information contained within my enrollment record.

| **Signature of Applicant:** | **Date:** |
|---|---|
| | |

Email completed form to Benefits@milwaukeecountywi.gov

Or

Submit via US Mail


Milwaukee County Benefit Division

901 N. 9th Street, Room 210, Milwaukee, WI 53233

Benefits@MilwaukeeCountywi.gov | Phone (414) 278-4198 | Fax (414) 223-1379