The Maryland-National Capital Park and Planning Commission
Life Insurance and AD&D Beneficiary Form

Return completed Beneficiary Form with your signature to the Health & Benefits Office:

By Mail: M-NCPPC, Health & Benefits Office
6611 Kenilworth Avenue, Suite 404 Riverdale, MD 20737

Email: benefits@mncppc.org Fax: 301-454-1687

Employee Name: _____ Employee ID Number:_____

Employee Email:_____

Please specify the type of life insurance this beneficiary form is for. If you are naming different beneficiaries for different types of insurance, fill out a separate form for each.

☐ **Basic Life** ☐ **AD&D** ☐ **Supplemental Life**

If you require additional space to list your beneficiaries, please make a copy of this form and submit all copies with the date and your signature.

Your Primary Beneficiaries

Primary Beneficiary(ies): All beneficiaries in this section will be considered primary. Proceeds will be paid in equal shares to primary beneficiaries who survive unless you indicate percentages. Total percentage must equal 100%.

Primary Beneficiary Name _____

Primary Beneficiary Address_____

Primary Beneficiary Email _____ Beneficiary Phone Number _____

Relationship _____ Enter the percentage distribution (Total must equal 100%) _____

Primary Beneficiary Name _____

Primary Beneficiary Address_____

Primary Beneficiary Email _____ Beneficiary Phone Number _____

Relationship _____ Enter the percentage distribution (Total must equal 100%) _____

Primary Beneficiary Name _____

Primary Beneficiary Address_____

Primary Beneficiary Email _____ Beneficiary Phone Number _____

Relationship _____ Enter the percentage distribution (Total must equal 100%) _____

List Your Contingent Beneficiaries

Contingent Beneficiary(ies): All beneficiaries in this section will be considered contingent beneficiaries. If no primary beneficiaries survive you, proceeds will be paid to the surviving contingent beneficiaries named in this section. Payment will be paid in equal shares unless you indicate percentages. Total percentage must equal 100%.

Contingent Beneficiary Name _____

Contingent Beneficiary Address_____

Contingent Beneficiary Email _____ Beneficiary Phone Number _____

Relationship _____ Enter the percentage distribution (Total must equal 100%) _____

Contingent Beneficiary Name _____

Contingent Beneficiary Address_____

Contingent Beneficiary Email _____ Beneficiary Phone Number _____

Relationship _____ Enter the percentage distribution (Total must equal 100%) _____

Contingent Beneficiary Name _____

Contingent Beneficiary Address_____

Contingent Beneficiary Email _____ Beneficiary Phone Number _____

Relationship _____ Enter the percentage distribution (Total must equal 100%) _____

Signature Required - This beneficiary form revokes all prior designations.

Employee's Signature:_____

Date:_____

3/2025