CALIFORNIA ASSOCIATION OF PROFESSIONAL SCIENTISTS

GROUP INSURANCE BENEFICIARY DESIGNATION FORM
CALIFORNIA ASSOCIATION OF PROFESSIONAL SCIENTISTS

Please print the information below

MEMBER'S FULL NAME _____

SOC. SEC. # ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Male ❑ Female ❑ Birthdate: Mo _____ Day _____ Year _____

BENEFICIARY DESIGNATION

Full Name _____

Street _____

City, State, Zip _____

Relationship to Insured _____

CAPS Member Signature

_____ Date _____

Note: This designation applies to all Life and AD&D coverages unless specifically requested. If more room is needed, on a separate piece of paper complete the information and attach to this card.