

MEMBERS MAY DESIGNATE PRIMARY AND CONTINGENT BENEFICIARIES. **Beneficiaries will receive equal shares, unless specific percentages are indicated.** Contingent beneficiaries become effective only when all primary beneficiaries have died prior to the member's death. A beneficiary may be a person, trust, estate, or other legal entity. You may designate as many primary or contingent beneficiaries as you feel necessary. If you need more space, please copy this sheet or attach another form CMS-617.

Beneficiary designations may be changed by the member at any time by submitting a new form.

If a beneficiary has not been designated, or all designated beneficiaries have died prior to the member's death, any proceeds payable shall be paid according to the Facility of Payment section of the State of Illinois Group Life Insurance Program book. Call Minnesota Life at 888-202-5525 if you would like assistance completing this form.

FIRST NAME	MIDDLE INITIAL	LAST NAME	DATE OF BIRTH (Mo/Day/Yr)	SOCIAL SECURITY NUMBER	
STREET ADDRESS			CITY	STATE	ZIP CODE
DATE EMPLOYED	MEMBER STATUS (Check all that apply)				
	<input type="checkbox"/> FULL TIME EMPLOYEE <input type="checkbox"/> PART TIME EMPLOYEE <input type="checkbox"/> IMMEDIATE ANNUITANT <input type="checkbox"/> DEFERRED ANNUITANT <input type="checkbox"/> SURVIVOR				

**Transaction Type**

- Initial Designation  
  Change of Beneficiary  
  Change of Address of Beneficiary

**Primary or Contingent Percent**

<input type="checkbox"/> P	<input type="checkbox"/> C	_____ %	_____	_____	_____	_____	_____	_____
			Last Name	First Name	MI	Relationship	Date of Birth	
			Street	City, State, Zip			Social Security Number	
<input type="checkbox"/> P	<input type="checkbox"/> C	_____ %	_____	_____	_____	_____	_____	_____
			Last Name	First Name	MI	Relationship	Date of Birth	
			Street	City, State, Zip			Social Security Number	
<input type="checkbox"/> P	<input type="checkbox"/> C	_____ %	_____	_____	_____	_____	_____	_____
			Last Name	First Name	MI	Relationship	Date of Birth	
			Street	City, State, Zip			Social Security Number	
<input type="checkbox"/> P	<input type="checkbox"/> C	_____ %	_____	_____	_____	_____	_____	_____
			Last Name	First Name	MI	Relationship	Date of Birth	
			Street	City, State, Zip			Social Security Number	
<input type="checkbox"/> P	<input type="checkbox"/> C	_____ %	_____	_____	_____	_____	_____	_____
			Last Name	First Name	MI	Relationship	Date of Birth	
			Street	City, State, Zip			Social Security Number	

**I hereby designate the above-named beneficiary(ies). I reserve the right, without consent of the beneficiary, to further change the beneficiary subject to any statutory restrictions. The above designation supersedes all prior designations of beneficiaries I have made.**

**Form must be signed and filed with Minnesota Life Insurance Company to validate designation.**

**Minnesota Life Insurance Company • 1 North Old Capitol Plaza #305 • Springfield, IL 62701**

MEMBER SIGNATURE	DAYTIME TELEPHONE NUMBER	EVENING TELEPHONE NUMBER	DATE
X _____	( )	( )	