INDIANA STATE POLICE
RETIREE SUPPLEMENTAL LIFE INSURANCE

Email completed form to ispbenefits@isp.in.gov

Effective Date: _____

☐ Retirement
☐ Beneficiary Change

Retiree Information		
Last Name	First Name	Middle Name
PE Number	Birth Date	Social Security Number
Address		Phone
Date Employed	Date Retired	

Employee Amount	Spouse Amount	Child Amount

Spouse's Information (if applicable) ☐ Check this box if not married		
Last Name	First Name	Middle Name
Birth Date	Social Security Number	

Dependent Information (if applicable)				
Last Name	First Name	Relationship	DOB	SSN
Last Name	First Name	Relationship	DOB	SSN
Last Name	First Name	Relationship	DOB	SSN

Primary Beneficiary Information			
Last Name	First Name	Middle Name	Relationship

Contingency Beneficiary Information				
Last Name	First Name	Relationship	DOB	SSN
Last Name	First Name	Relationship	DOB	SSN
Last Name	First Name	Relationship	DOB	SSN

- Unless otherwise provided, where two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries, if surviving the insured, or to the survivor or survivors. If no beneficiary survives, payment shall be made in accordance with the terms of the policy.
- This designation revokes any and all previous designations. The right to further change the beneficiary is reserved unto the insured.
- I accept the insurance provided by my Employer's Group Insurance Plan and authorize deductions from my earnings of the required contributions, if any toward the cost of the insurance. This authorization applies only if the employee contributions are required.

Signature	Date