



**State of Oklahoma  
Office of Management and Enterprise Services  
Employees Group Insurance Department  
Outstanding Disability Benefits Beneficiary Designation**

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If you receive disability benefits through the HealthChoice Disability Plan, you have the option to designate a beneficiary to receive your final disability benefit in the event of your death.

If you elect to name a beneficiary, you must complete the “Outstanding Disability Benefits Beneficiary Designation” form at the time you complete your disability application. If you want to change your beneficiary at some point in the future, it is your responsibility to complete and submit a new beneficiary form to GHS Property and Casualty Insurance Company (GHS). For example, if you name your spouse and are later divorced, you may want to complete a new form.

**Primary Beneficiary:** Receives priority distribution upon your death.

**Contingent Beneficiary:** Receives distribution only if the primary beneficiary(ies) are deceased at the time of your death.

*If you do not elect to name a beneficiary, GHS will issue your final disability benefit to your estate. Please be advised that access to the funds paid to an estate may be delayed due to the probate process.*

**Instructions:**

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1. Complete and **sign** the “Outstanding Disability Benefits Beneficiary Designation” form.
2. Return the form to GHS and keep a copy for your records.

GHS Property and Casualty Insurance Company  
P.O. Box 57208  
Oklahoma City, OK 73157-7208

Fax: 1-918-549-3071

**Please keep all beneficiary information current.**



**Office of Management and Enterprise Services  
Employees Group Insurance Department  
Outstanding Disability Benefits Beneficiary Designation Form**

Employee's Name: \_\_\_\_\_ SSN or Member ID: \_\_\_\_\_

<b>Primary Beneficiary:</b>			
Full Name: _____		DOB: (mm/dd/yyyy): _____	
Social Security Number: _____		Relationship: _____	
Address: _____			
Street	City	State	Zip Code
Phone Numbers: _____		_____	
Home	Work	Cell	

<b>Beneficiary:</b>	Primary: _____	<b>OR</b>	Contingent: _____
Full Name: _____		DOB: (mm/dd/yyyy): _____	
Social Security Number: _____		Relationship: _____	
Address: _____			
Street	City	State	Zip Code
Phone Numbers: _____		_____	
Home	Work	Cell	

<b>Beneficiary:</b>	Primary: _____	<b>OR</b>	Contingent: _____
Full Name: _____		DOB: (mm/dd/yyyy): _____	
Social Security Number: _____		Relationship: _____	
Address: _____			
Street	City	State	Zip Code
Phone Numbers: _____		_____	
Home	Work	Cell	

<b>Beneficiary:</b>	Primary: _____	<b>OR</b>	Contingent: _____
Full Name: _____		DOB: (mm/dd/yyyy): _____	
Social Security Number: _____		Relationship: _____	
Address: _____			
Street	City	State	Zip Code
Phone Numbers: _____		_____	
Home	Work	Cell	

\_\_\_\_\_  
PRINT YOUR FULL NAME                      SIGNATURE                      DATE