MEDIVEST®
MSP Compliance Solutions

Beneficiary Designation Form

Claimant/Applicant Information

Claimant/Applicant Full Name	Date of Birth (mm/dd/yyyy)	Social Security #	Claimant/Applicant Telephone Number

Claimant/Applicant Address	City	State	Zip Code

Designated Beneficiary Information

Beneficiary Full Name	Date of Birth (mm/dd/yyyy)	Social Security #	Relation to Claimant/Applicant

Claimant/Applicant Address	City	State	Zip Code

Percentage Reversionary to the Beneficiary: _____%	☐ Primary ☐ Secondary

Beneficiary Full Name	Date of Birth (mm/dd/yyyy)	Social Security #	Relation to Claimant/Applicant

Claimant/Applicant Address	City	State	Zip Code

Percentage Reversionary to the Beneficiary: _____%	☐ Primary ☐ Secondary

Beneficiary Full Name	Date of Birth (mm/dd/yyyy)	Social Security #	Relation to Claimant/Applicant

Claimant/Applicant Address	City	State	Zip Code

Percentage Reversionary to the Beneficiary: _____%	☐ Primary ☐ Secondary

_____ _____
Claimant/Applicant (or authorized agent) Signature Date

_____
Printed Full Name of Authorized Agent (if signator is not claimant/appplicant).
If signed by an authorized agent of the claimant/applicant, please attach letter of authority, if applicable.

_____
Relation to Claimant/Applicant (i.e., guardian, spouse, parent, etc)

STATE OF _____
COUNTY OF _____

The foregoing instrument was acknoledged before me this _____ day of _____, 20____, by _____.
Signator Above

_____
Signature of Notary Public

_____
Name of Notary, Typed, Printed or Stamped

Personally Known _____ OR Produced Identification _____ Type of Identification Produced _____