THIS FORM *WILL NOT* ENROLL YOU IN BENEFITS
To enroll go to: http://www.myabx.com/benefits
Or call (800) 736-3973 ext. 62157

Full-time Beneficiary Form

Employee Information

Employee Name (Last, First, M.I.) *Please print*	Employee No.	Social Security No.	Marital Status ❑ Married ❑ Single
Home Address	City	State	Zip

Dept. Name	Location/Station	Hire Date	Full Time Date	Sex ❑ Female ❑ Male	Date of Birth

Life/AD&D Insurance / Business Travel Accident

Beneficiary Designation — Primary

Relationship	Name (Last, First, M.I.) and Address	Social Security No.	Date of Birth	Distribution (% of Total Benefit) *Must Equal 100%*

Beneficiary Designation — Secondary | *Must Equal 100%*

Voluntary Accident Insurance

Beneficiary Designation — Primary

Relationship	Name (Last, First, M.I.) and Address	Social Security No.	Date of Birth	Distribution (% of Total Benefit) *Must Equal 100%*

Beneficiary Designation — Secondary | *Must Equal 100%*

Employee Signature _____ **Date** _____

Please Return to ILN — Benefits 2061H
145 Hunter Drive ♦ Wilmington, OH 45177