



LIFE INSURANCE BENEFICIARY DESIGNATION FORM

EMPLOYEE NAME: _____
SOCIAL SECURITY / ID No.: _____
EFFECTIVE DATE: _____
DATE OF BIRTH: _____

I request that the beneficiary under this Group Certificate be as indicated below. Unless otherwise provided in this request, if 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 in accordance with the terms of the policy. It is the right of the insured or owner, not other insured, to change the beneficiary designation.

PRIMARY ELECTION(S)

FULL NAME AND ADDRESS OF BENEFICARY OR BENEFICIARIES:

1. (Required)	2. (Optional)
NAME	NAME
ADDRESS	ADDRESS
CITY, STATE, ZIP	CITY, STATE, ZIP
DATE OF BIRTH: _____	DATE OF BIRTH: _____
RELATIONSHIP: _____	RELATIONSHIP: _____

Spouse signature if NOT sole beneficiary: _____

IF LIVING, OTHERWISE TO:

SECONDARY ELECTION(S)

FULL NAME AND ADDRESS OF BENEFICARY OR BENEFICIARIES:

1. (Required)	2. (Optional)
NAME	NAME
ADDRESS	ADDRESS
CITY, STATE, ZIP	CITY, STATE, ZIP
DATE OF BIRTH: _____	DATE OF BIRTH: _____
RELATIONSHIP: _____	RELATIONSHIP: _____

EMPLOYEE SIGNATURE: _____
DATE SIGNED: _____