

BENEFICIARY DESIGNATION FORM

Employer: _____

Policy Number: _____ Group ID#: _____

State: _____ Insured's Name: _____

Certificate Number: _____

BENEFICIARY DESIGNATION

Primary Designation: _____

Address: _____

Relationship to Insured: _____

SSN: _____

Contingent Beneficiary: _____

Address: _____

Relationship to Insured: _____

SSN: _____

Note: Contingent Beneficiary will receive benefits only if Primary Beneficiary does not survive you. If more than one Primary or Contingent Beneficiary is wanted, please attach a separate sheet to reflect this.

Insured's Signature: _____ Date Signed: _____