

# Beneficiary Form

## Group Term Life Insurance

<b>Policy Holder: (Employer)</b>	<b>Group Number:</b>
Individual Covered Person: (Print Name)	SS #

**Note:** This Beneficiary Designation cancels any prior beneficiary designation and shall be effective on the date received by the Company.

THE BENEFICIARY FOR THIS POLICY SHALL BE:

a)	Primary Beneficiary	Percentage	Relationship to Insured	Address
b)	Contingent Beneficiary	Percentage	Relationship to Insured	Address

INSURED: \_\_\_\_\_

Signature

Date

WITNESS: \_\_\_\_\_

Print Name

Date

Send completed form to your Benefits Administrator.