Beneficiary Designation Form

❑ New ❑ Change

EMPLOYER INFORMATION			
GROUP NUMBER	SUBGROUP/CLASS	EMPLOYER NAME	EFFECTIVE DATE

EMPLOYEE INFORMATION					
LAST NAME	FIRST	MI	SEX (M/F)	BIRTHDATE (MM/DD/YYYY)	HIRE DATE
CONTRACT NUMBER	SOCIAL SECURITY #	HOME PHONE		WORK PHONE	
MAILING ADDRESS	CITY	STATE	ZIP	E-MAIL ADDRESS	

Enrollee's Last Name _____First Name _____Subscriber Number_____Group Number/Subgroup_____/____

GROUP TERM LIFE with or without embedded ACCIDENTAL DEATH benefit. (GTL & AD&D)

	Last Name	First Name	M	Date of Birth	Address	Social Security #	Relationship to You	Percent
Primary Beneficiary(ies)								_____%
								_____%
								_____%
								Must = 100%
Contingent Beneficiary(ies)	Last Name	First Name	M	Date of Birth	Address	Social Security #	Relationship to You	Percent
								_____%
								_____%
								_____%
								Must = 100%

VOLUNTARY TERM LIFE with or without embedded ACCIDENTAL DEATH benefit. (VGTL & VAD&D)

	Last Name	First Name	M	Date of Birth	Address	Social Security #	Relationship to You	Percent
Primary Beneficiary(ies)								_____%
								_____%
								_____%
								Must = 100%
	Last Name	First Name	M	Date of Birth	Address	Social Security #	Relationship to You	Percent
Contingent Beneficiary(ies)								_____%
								_____%
								_____%
								Must = 100%

-Over-

VOLUNTARY HIGH LIMIT ACCIDENTAL DEATH (VHL/VHLF)								
	Last Name	First Name	M	Date of Birth	Address	Social Security #	Relationship to You	Percent
Primary Beneficiary(ies)								_____%
Contingent Beneficiary(ies)								_____%

I designate the beneficiary(ies) shown above to receive sums which may become due on account of my death under the group coverage(s) provided and approved by SNL. If you use this form or a system to change beneficiary designation for a specific coverage, you hereby revoke all prior beneficiary designations for that coverage.

_____ _____

Employee's Signature Employee's Signature Date