## **Beneficiary Designation Form**

<b>□</b> New	☐ Change
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					EMPI	LOYE	R INFORM	ATION					
GROUP NUMBE	P NUMBER SUBGROUP/CLASS E				EMPLOYER NAME					EFFECTIVE DATE			
EMDI OVEE INI	FORMATION												
EMPLOYEE INFORMATION  LAST NAME FIRST			MI			SEX (M/F) BIRTHDATE (MM/DI		IM/DD/YYY	DD/YYYY) HIRE DATE				
CONTRACT AND ADED		CCUDITY #		ПОМІ	7 DIJO	HONE		W	WORK PHONE				
		SOCIAL SI	SOCIAL SECURITY #				HOME PHONE			WORK PHONE			
MAILING ADDRESS		CITY				STATE			ZIP	E	E-MAIL ADDRESS		
Enrollee's Last Name			First Name				Subscriber Number			Group Number/Subgroup			
GROUP TERM L	IFE with or wi	hout embedd	led ACCIDE	NTAL D	EATH be	enefit.	(GTL & AL	0&D)					
	Last Name	;	First Name		Date o	f Birth	rth Address		Socia	l Security	# Relationship to You	Percent	
Primary												%	
Beneficiary(ies)												%	
												%	
				•	•		•		•		•	Must = 100%	
Contingent Beneficiary(ies)	Last Name		First Name M		Date o	Date of Birth		Address Social		l Security	# Relationship to You	Percent	
												%	
Deficiencial y(les)												%	
												%	
				J.							-	Must = 100%	
VOLUNTARY TH	ERM LIFE with	or without e	mbedded A(	CCIDEN	TAL DEA	ATH b	enefit. (VG	TL & VAD&D)					
	Last Name	;	First Name	M	Date o	of Birth	Į.	Address	Socia	l Security	# Relationship to You	Percent	
Primary												%	
Beneficiary(ies)												%	
												%	
		<u> </u>		l					<u> </u>		-	Must = 100%	
	Last Name	;	First Name	М	Date o	of Birth	ı	Address	Soc	ial Securit	y Relationship to You	Percent	
Contingent												%	
Beneficiary(ies)												%	
												%	
		l .		l l	1		I .				•	Must = 100%	

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 Date							's Signature Date				