



BENEFICIARY DESIGNATION FORM

Employer: _____

Policy Number: _____ Group ID#: _____

State: _____ Insured's Name: _____

Certificate Number: _____ MCD ID# _____

<p>BENEFICIARY DESIGNATION</p> <p>Primary Designation: _____</p> <p>Address: _____</p> <p>Relationship to Insured: _____</p> <p>SSN: _____</p> <p>Contingent Beneficiary: _____</p> <p>Address: _____</p> <p>Relationship to Insured: _____</p> <p>SSN: _____</p>

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: _____