

	De	esignation of B	Senefic	ciary		
Policyholder				Policy Number(s)		
Insured Name				Social Security Number		
I hereby designate the fol Primary Beneficiary(ies		y (ies) under the a	above p	olicy nui	mber(s):	
Full Name and Address (Plo	l Name and Address (Please Print)		Date of Birth		Relationship	Social Security Number
* If no percentages are in	ndicated, benefits will be	divided equally t	etween	all prim	ary beneficiarie	es.
Contingent Beneficiary	(ies) (applicable only if y	you are not surviv	ed by o	ne or mo	ore primary ben-	eficiaries)
Full Name and Address (Please Print)		Percentage* (Must total 100%)	Date (of Birth	Relationship	Social Security Number
* If no percentages are in contingent beneficiaries.		yable to continger	nt benef	iciaries v	will be divided	equally between all
 Unless you indicate of the surviving beneficities 	gnation revokes all revoc otherwise, if any beneficia iaries of the same class (p mary or contingent) survi	ary predeceases ye primary or conting	ou, that gent).	t benefici	iary's share wil	l be divided pro-rata among
Date	Signature of Insured					