



Health Care Providers Group Insurance Plan BENEFICIARY REQUEST

PLAN MEMBER NAME: _____

PID #: (where applicable): _____

PART A— CHANGE TO BENEFICIARY DESIGNATION

I, _____, WISH TO

Add a beneficiary

Change the current beneficiary designation

AND I UNDERSTAND THAT BY USING THIS FORM TO DESIGNATE OR CHANGE A DESIGNATION REVOKES ONLY THOSE NAMED BENEFICIARIES FOR THE COVERAGE INDICATED BY ME BELOW:

Basic Life and Basic ADD&D

Optional Life

I REVOKE ALL PREVIOUS BENEFICIARY DESIGNATIONS FOR THE COVERAGE INDICATED ABOVE AND DECLARE THAT ALL BENEFITS PAYABLE UNDER THE POLICY AFTER MY DEATH FOR THE COVERAGE INDICATED ABOVE SHALL BE PAID ACCORDING TO THE FOLLOWING:

Primary Beneficiary(ies): *Required.* The first choice recipient(s) of the insured's death benefit.

First Name	Last Name	Relationship	% Allocated

Contingent Beneficiary(ies): *Optional.* The recipient(s) of the death benefit if the primary beneficiary dies before the insured.

First Name	Last Name	Relationship	% Allocated

Trustee: *Required for beneficiaries under age 18.* Person named to accept death benefit in trust on behalf of a minor.

First Name	Last Name	Relationship

* In the event that all beneficiaries predecease the employee, benefits shall be paid to the employee's estate.

I authorize all changes requested above to be made to my account

SIGNATURE: _____

DATE: _____