BENEFICIARY DESIGNATION

☐ Initial

☐ Change – Revoking hereby any previous designation which may be inconsistent herewith, I direct that the insurance proceeds, payable under my Employer's Group Insurance Plan in the event of my death, be paid as indicated below.

Employee Name		**Social Security Number**	- -
Policyholder/Employer	PACIFIC UNION COLLEGE	**Policy/Employer Number**	

NAMING THE BENEFICIARY

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies), please indicate their FULL name, address, social security number, relationship, and, if a minor, the age of that minor. If the beneficiary is not related either by blood or marriage, insert the words, "Not Related." If you need assistance, contact your company representative or your own legal counsel.

PRIMARY BENEFICIARY(IES)

I designate the person(s) named below as my primary beneficiary(ies) to receive payment under the policy in the event of my death. The share of any primary beneficiary who is no longer living or is otherwise disqualified by law at the time of my death, will pass to any remaining beneficiary(ies) in the order I designated.

Name: ______________________________

Address: ______________________________

Social Security Number: _____-____-________ Age (if minor): __________ Relationship: ______________________________

Name: ______________________________

Address: ______________________________

Social Security Number: _____-____-________ Age (if minor): __________ Relationship: ______________________________

Name: ______________________________

Address: ______________________________

Social Security Number: _____-____-________ Age (if minor): __________ Relationship: ______________________________

CONTINGENT BENEFICIARIES

Name: ______________________________

Address: ______________________________

Social Security Number: _____-____-________ Age (if minor): __________ Relationship: ______________________________

Name: ______________________________

Address: ______________________________

Social Security Number: _____-____-________ Age (if minor): __________ Relationship: ______________________________

The right to change the beneficiary(ies) without the consent of said beneficiary(ies) is reserved. By signing this document, I understand and agree to the following: This beneficiary designation revokes all prior designations. This beneficiary designation form will apply to my Insurance Plan established in connection with my employer's plan. If more than one primary beneficiary is named and no percentages are indicated, payment will be made in equal shares to my primary beneficiary(ies) who survives me or if the percentages listed do not add up to 100% my Insurance Company will disburse the benefit pursuant to its discretion and/or pursuant to the above policy provisions if applicable.

Signature of Employee: ______________________________ Date: ____________________

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