UnitedHealthcare®
A UnitedHealth Group Company

# Beneficiary Form

## Group Term Life Insurance

| **Policy Holder:**<br>**(Employer)** | **Group**<br>**Number:** |
|---|---|
| Individual Covered Person:<br>(Print Name) | SS#: |

**Note:** This Beneficiary Designation cancels any prior beneficiary designation and shall be effective on the date received by the Company.

THE BENEFICIARY FOR THE POLICY SHALL BE:

| **a)** | **Primary Beneficiary** | **Percentage** | **Relationship to Insured** | **Address** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| **b)** | **Contingent Beneficiary** | **Percentage** | **Relationship to Insured** | **Address** |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

INSURED: _____ WITNESS: _____

Signature _____ Print Name _____

Date _____ Date _____

Send completed form to the Benefits Office in Human Resources.