

GUARDIAN* Northeast Regional Office P.O. Box 26050 P.O. Box 8012 P.O. Box 425 P.O. Box 2454 Spokane, WA 99210-2454 Spokane, WA 99210-2454 Change Form

| PLEASE TYPE or PRINT CLEARLY. (The entire form, properly completed, signed and dated by the Insured, must be submitted or the changes cannot be processed.) EMPLOYER NAME (LAST, FIRST, M) EMPLOYEE NOME ADDRESS (STREET, CITY, STATE, 2IP) IT AUTHORIZE Guardian or my employer to record and consider the individuals/instructions that I have named on this form as beneficiaries for benefits under the applicable employee benefits plan. (PLEASE COMPLETE THE APPROPRIATE SECTIONS ONLY.) BENEFICIARY INFORMATION: (Complete to designate a beneficiary or change the beneficiary designation); include full proper name, relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wile, friend, son, doughtor. Primary: 1) Name Date of Birth Relationship Social Security # Address Contingent: 1) Name Date of Birth Relationship Social Security # Address Contingent: 1) Name Date of Birth Relationship Social Security # Address 2) Name Date of Birth Relationship Social Security # Address Contingent: 1) Name Date of Birth Relationship Social Security # Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF HINDINGS CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) TO HOW IS) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED | Contingent: 1) Name Date of Birth Relationship Social Security # 1/4 Name Date of Birth Relationship Address 2) Name Date of Birth Relationship Address Contingent: 1) Name Date of Birth Relations | CONTINUITY TO Lenigh valley, PA 10002-0000 Appleton, W1 34912-0012 E. Bhugewater, WA 02333-0423 Spokalle, WA 99210-2404 Charige Form | | | | | | | | | |
|--|--|--|---------------------------------------|----------------------|---------------------|-------------------|----------------------|-------------------|------------|--|--|
| BENEFICIARY INFORMATION: (CONTROL OF RELIGIOUS NAME (LAST FIRST, M.) AUTHORIZE Guardian or my employer to record and consider the individuals/instructions that I have named on this form as beneficiaries for benefits under the applicable employee benefits plan. (PLEASE COMPLETE THE APPROPRIATE SECTIONS ONLY.) BENEFICIARY INFORMATION: (Complete to designate a beneficiary or change the beneficiary designation); Include full proper name, relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wite, friend, son, daughter. Primary: 1) | EMENOMERANDECAGE NAME: EMPLOYER NAME (AST, RRS) MI) LAUTHORIZE Guardian or my employer to record and consider the individuals/instructions that I have named on this form as beneficiaries for benefits under the applicable employee benefits plan. (PLEASE COMPLETE THE APPROPRIATE SECTIONS ONLY.) BENEFICIARY INFORMATION: (Complete to designate a beneficiary or change the beneficiary designation): include full proper name, relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wife, friend, son, datughter. Primary: 1) Name Date of Birth Relationship Address Contingent: 1) Name Date of Birth Relationship Social Security # W. Address Contingent: 1) Name Date of Birth Relationship Social Security # W. Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made to the estate of the insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided herein. If the Group Plan. CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) TO POW 16) SORM/URE OF WINNESS BOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIANOT THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed The NAME of the BENEFICIARY has been changed New Employee | | | | | | | | | | |
| EMPLOYEE NAME (LAST, PIRST, M.) EMPLOYEE NAME (LAST, PIRST, M.) EMPLOYEE NAME (LAST, PIRST, M.) EMPLOYEE HOME ADDRESS (STREET, CITY, STATE, ZIP) I AUTHORIZE Guardian or my employer to record and consider the individuals/instructions that I have named on this form as beneficiaries for benefits under the applicable employee benefits plan. (PLEASE COMPLETE THE APPROPRIATE SECTIONS ONLY.) BENEFICIARY INFORMATION: (Complete to designate a beneficiary or change the beneficiary designation); Include full proper name, relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wife, friend, son, daughter. Primary: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 1) If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiary is designated on the Insured, unless otherwise provided herein, If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided herein, If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided herein, If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided herein, If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided herein, If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided herein, If no designated beneficiary survives the Insured, unless otherwise provided herein, If no designated beneficiary survives the Insured. CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed | EMPLOYEE HOME (LMST. HIRST, NL) INDICATE HOME ADDRESS (STREET, CITY, STATE, JBP) I AUTHORIZE Guardian or my employer to record and consider the individuals/instructions that I have named on this form as beneficiaries for benefits under the applicable employee benefits plan. (PLEASE COMPLETE THE APPROPRIATE SECTIONS ONLY.) BENEFICIARY INFORMATION: (Complete to designate a beneficiary or change the beneficiary designation): Include full proper name, relationship and social security number of proposed beneficiary or change the beneficiary designation): Include full proper name, relationship and social security number of proposed beneficiary or change the beneficiary designation): Include full proper name, relationship and social security number of proposed beneficiary or change the beneficiary designation; Include full proper name, relationship and social security in making the proper name, and designated security in making the proper name of the proper name, relationship and social security in the proper name, and designated security in the proper name, and designated, settlement will be made in equal share so such of the designated beneficiary is designated and no percentage has been designated, settlement will be made in equal share so such of the designated beneficiary is university in the proper name, and the proper n | changes cannot be processed.) | | | | | | | | | |
| I AUTHORIZE Guardian or my employer to record and consider the individuals/instructions that I have named on this form as beneficiaries for benefits under the applicable employee benefits plan. (PLEASE COMPLETE THE APPROPRIATE SECTIONS ONLY.) BENEFICIARY INFORMATION: (Complete to designate a beneficiary or change the beneficiary designation); Include full proper name, relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wife, friend, son, adayther. Primary: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 1I more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiares as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF RISURED ALL SIGNATURES WUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM INSURED'S NAME (Complete only if the name has been legally changed.) FROM INSURED'S NAME (Complete only if the name has been legally changed.) FROM INSURED'S NAME (Complete only if the name has been legally changed.) FROM INSURED'S NAME (Complete only if the name has been legally changed.) FROM INSURED'S NAME (Complete only if the name has been legally changed.) | I AUTHORIZE Guardian or my employer to record and consider the individuals/instructions that I have named on this form as beneficiaries for benefits under the applicable employee benefits plant (PLEASE COMPLETE THE APPROPRIATE SECTIONS ONLY.) BENEFICIARY INFORMATION: (Complete to designate a beneficiary or change the beneficiary designation); Include full proper name, relationship and social security number of proposed beneficiary or change the beneficiary designation); Include full proper name, relationship and social security number of proposed beneficiary (s) - Le. Mary A. Doe, and relationship - Le. husband, wife, friend, son, daughter. Primary: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Name Name Name Name Name Name Name | EMPLOYER/PLAN | NHOLDER NAME: | | | | | GROUP I | NUMBER | | |
| I AUTHORIZE Guardian or my employer to record and consider the individuals/instructions that I have named on this form as beneficiaries for benefits under the applicable employee benefits plan. (PLEASE COMPLETE THE APPROPRIATE SECTIONS ONLY.) BENEFICIARY INFORMATION: (Complete to designate a beneficiary or change the beneficiary designation); Include full proper name, relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wife, friend, son, adayther. Primary: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 1I more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiares as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF RISURED ALL SIGNATURES WUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM INSURED'S NAME (Complete only if the name has been legally changed.) FROM INSURED'S NAME (Complete only if the name has been legally changed.) FROM INSURED'S NAME (Complete only if the name has been legally changed.) FROM INSURED'S NAME (Complete only if the name has been legally changed.) FROM INSURED'S NAME (Complete only if the name has been legally changed.) | I AUTHORIZE Guardian or my employer to record and consider the individuals/instructions that I have named on this form as beneficiaries for benefits under the applicable employee benefits plant (PLEASE COMPLETE THE APPROPRIATE SECTIONS ONLY.) BENEFICIARY INFORMATION: (Complete to designate a beneficiary or change the beneficiary designation); Include full proper name, relationship and social security number of proposed beneficiary or change the beneficiary designation); Include full proper name, relationship and social security number of proposed beneficiary (s) - Le. Mary A. Doe, and relationship - Le. husband, wife, friend, son, daughter. Primary: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Name Name Name Name Name Name Name | | | | | | | | | | |
| I AUTHORIZE Guardian or my employer to record and consider the individuals/instructions that I have named on this form as beneficiaries for benefits under the applicable employee benefits plan. (PLEASE COMPLETE THE APPROPRIATE SECTIONS ONLY.) BENEFICIARY INFORMATION: (Complete to designate a beneficiary or change the beneficiary designation); Include full proper name, relationship and social security number of proposed beneficiary (s) - i.e. Mary A. Doe, and relationship - i.e. husband, wife, friend, son, daughter. Primary: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 3) Name Date of Birth Relationship Social Security # % Address 4) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 3) Name Date of Birth Relationship Social Security # % Address 4) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address Date of Birth Relationship Social Security # % Address Date of Birth Relationship Social Security # % Address Date of Birth Relationship Social Security # % Address Date of Birth Relationship Social Security # % Address Date of Birth Relationship Social Security # % Address Date of Birth Relationship Social Security # % Address Date of Birth Relationship Social Security # % Address Date of Birth Relationship Social Security # Date Date of Birth Relationship Social Security # Date Date of Birth Relationship Social Security # Date Date of Birth Relationship Social Security | AUTHORIZE Guardian or my employer to record and consider the individuals/instructions that I have named on this form as beneficiaries for benefits under the applicable employee benefits plan. (PLEASE COMPLETE THE APPROPRIATE SECTIONS ONLY.) BENEFICIARY INFORMATION: (Complete to designate a beneficiary or change the beneficiary designation); include full proper name, relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wife, friend, son, daughter. Primary: 1) | EMPLOYEE NAM | E (LAST, FIRST, M.) | | | | | SOCIAL | SECURITY # | | |
| I AUTHORIZE Guardian or my employer to record and consider the individuals/instructions that I have named on this form as beneficiaries for benefits under the applicable employee benefits plan. (PLEASE COMPLETE THE APPROPRIATE SECTIONS ONLY.) BENEFICIARY INFORMATION: (Complete to designate a beneficiary or change the beneficiary designation); Include full proper name, relationship and social security number of proposed beneficiary (s) - i.e. Mary A. Doe, and relationship - i.e. husband, wife, friend, son, daughter. Primary: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 3) Name Date of Birth Relationship Social Security # % Address 4) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 3) Name Date of Birth Relationship Social Security # % Address 4) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address Date of Birth Relationship Social Security # % Address Date of Birth Relationship Social Security # % Address Date of Birth Relationship Social Security # % Address Date of Birth Relationship Social Security # % Address Date of Birth Relationship Social Security # % Address Date of Birth Relationship Social Security # % Address Date of Birth Relationship Social Security # % Address Date of Birth Relationship Social Security # Date Date of Birth Relationship Social Security # Date Date of Birth Relationship Social Security # Date Date of Birth Relationship Social Security | AUTHORIZE Guardian or my employer to record and consider the individuals/instructions that I have named on this form as beneficiaries for benefits under the applicable employee benefits plan. (PLEASE COMPLETE THE APPROPRIATE SECTIONS ONLY.) BENEFICIARY INFORMATION: (Complete to designate a beneficiary or change the beneficiary designation); include full proper name, relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wife, friend, son, daughter. Primary: 1) | | | | | | | | | | |
| BENEFICIARY INFORMATION: (Complete to designate a beneficiary or change the beneficiary designation): Include full proper name, relationship and social security number of proposed beneficiary or change the beneficiary designation): Include full proper name, relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wife, friend, son, daughter. Primary: 1) Name | BENEFICIARY INFORMATION: (Complete to designate a beneficiary or change the beneficiary designation); Include full proper name, relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wife, friend, son, advanters. Primary: 1) Name Date of Birth Date of Birth Relationship Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 1) Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED SIGNATURE OF WITHESS (SORIECHE OTHER THAN BENEFICIARY) DATE ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW 18) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIANO'T THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. | EMPLOYEE HOM | IE ADDRESS (STREET, CITY, STATE, ZIP) | | | | | l . | | | |
| BENEFICIARY INFORMATION: (Complete to designate a beneficiary or change the beneficiary designation): Include full proper name, relationship and social security number of proposed beneficiary or change the beneficiary designation): Include full proper name, relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wife, friend, son, daughter. Primary: 1) Name | BENEFICIARY INFORMATION: (Complete to designate a beneficiary or change the beneficiary designation); Include full proper name, relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wife, friend, son, advanters. Primary: 1) Name Date of Birth Date of Birth Relationship Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 1) Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED SIGNATURE OF WITHESS (SORIECHE OTHER THAN BENEFICIARY) DATE ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW 18) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIANO'T THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. | | | | | | | | | | |
| BENEFICIARY INFORMATION: (Complete to designate a beneficiary or change the beneficiary designation): Include full proper name, relationship and social security number of proposed beneficiary or change the beneficiary designation): Include full proper name, relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wife, friend, son, daughter. Primary: 1) Name | BENEFICIARY INFORMATION: (Complete to designate a beneficiary or change the beneficiary designation); Include full proper name, relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wife, friend, son, advanters. Primary: 1) Name Date of Birth Date of Birth Relationship Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 1) Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED SIGNATURE OF WITHESS (SORIECHE OTHER THAN BENEFICIARY) DATE ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW 18) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIANO'T THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. | | | | | | | | | | |
| BENEFICIARY INFORMATION: (Complete to designate a beneficiary or change the beneficiary designation): Include full proper name, relationship and social security number of proposed beneficiary or change the beneficiary designation): Include full proper name, relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wife, friend, son, daughter. Primary: 1) Name | BENEFICIARY INFORMATION: (Complete to designate a beneficiary or change the beneficiary designation); Include full proper name, relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wife, friend, son, advanters. Primary: 1) Name Date of Birth Date of Birth Relationship Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 1) Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED SIGNATURE OF WITHESS (SORIECHE OTHER THAN BENEFICIARY) DATE ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW 18) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIANO'T THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. | I AUTHORIZE Guardian or my employer to record and consider the individuals/instructions that I have named on this form as | | | | | | | | | |
| BENEFICIARY INFORMATION: (Complete to designate a beneficiary or change the beneficiary designation); Include full proper name, relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wife, friend, son, daughter. Primary: 1) Name Date of Birth Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiary as unrives the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY) DATE AATE AATE AATE SIGNATURE OF INSURED AND CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | BENEFICIARY INFORMATION: (Complete to designate a beneficiary or change the beneficiary designation); Include full proper name, relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wife, friend, son, daughter. Primary: 1) Name Date of Birth Relationship Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF PASURED ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM RWAS) TO ROW IS) TO ROW IS) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIANY THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. | | | | | | | | | | |
| BENEFICIARY INFORMATION: (Complete to designate a beneficiary or change the beneficiary designation); include full proper name, relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wile, friend, son, daughter. Primary: 1) Name | BENEFICIARY INFORMATION: (Complete to designate a beneficiary or change the beneficiary designation); Include full proper name, relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wife, friend, son, daughter. Primary: 1) Name | | | | | E SECTIONS | ONLY.) | | | | |
| relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wife, friend, son, daughter. Primary: 1) | relationship and social security number of proposed beneficiary(s) - i.e. Mary Ä. Doe, and relationship - i.e. husband, wife, friend, son, daughter. Primary: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured. SIGNATURE OF WITNESS (SOMECNE OTHER THAN BENEFICIARY) ALL SIGNATURES MUST BE IN INK CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. THE BENEFICIARY has been changed The NAME of the BENEFICIARY has been changed The NAME of the BENEFICIARY has been | | | | | | , | | | | |
| Primary: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY) DATE ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | Primary: 1) Name Date of Birth Relationship Social Security # % Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED ALL SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY) DATE CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed The NAME of the BENEFICIARY has been changed New Employee | BENEFICIA | RY INFORMATION: (Complete to | designate a bene | ficiary or change | the beneficiar | y designation); In | clude full prop | er name, | | |
| Primary: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiary survives the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY) DATE ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | Primary: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 3) If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY) DATE ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY Ø DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed New Employee New | | and social security number of prop | osed beneficiary(| s) - i.e. Mary A. L | Doe, and relati | onship - i.e. husb | and, wife, frier | d, son, | | |
| Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | Address 2) Name Date of Birth Relationship Social Security # % Address Contingent: 1) Date of Birth Relationship Social Security # % Address Contingent: 1) Date of Birth Relationship Social Security # % Address Contingent: 1) Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY) DATE ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed New Employee New Employee | daughter. | | | | | | | | | |
| Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | Address 2) Name Date of Birth Relationship Social Security # % Address Contingent: 1) Date of Birth Relationship Social Security # % Address Contingent: 1) Date of Birth Relationship Social Security # % Address Contingent: 1) Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY) DATE ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed New Employee New Employee | Drimon 4\ | | | | | | | | | |
| Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY) DATE CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein, if no designated beneficiary survives the Insured, unless otherwise provided herein, if no designated beneficiary survives the Insured, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein, if no designated beneficiary survives the Insured, unless otherwise provided herein, if no designated beneficiary survives the Insured, unless otherwise provided herein, if no designated beneficiary survives the Insured, unless otherwise provided herein, if no designated beneficiary survives the Insured, unless otherwise provided herein, if no designated beneficiary survives the Insured, unless otherwise provided herein, if no designated beneficiary survives the Insured, unless otherwise provided herein, if no designated beneficiary survives the Insured, unless otherwise provided herein, if no designated beneficiary survives the Insured, unless otherwise provided herein, if no designated beneficiary survives the Insured. ALL SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY) DATE ALL SIGNATURE OF WITNESS (SOMEON | Primary. 1) | | | Date of Birth | Relationshir | <u> </u> | Social Security # | | | |
| 2) Name Date of Birth Relationship Social Security # % Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiary as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured of the Social Security # Date ALL SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY) DATE CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | 2) Name | | Turno . | | Date of Bitti | rtolationom | , | Coolai Cooanty ii | ,0 | | |
| Name Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made in equal shares to such of the Group Plan. SIGNATURE OF INSURED ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY) DATE ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed The NAME of the BENEFICIARY has been changed New Employee | | Address | | | | | | | | |
| Name Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made in equal shares to such of the Group Plan. SIGNATURE OF INSURED ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | Address Contingent: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY) DATE ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed The NAME of the BENEFICIARY has been changed New Employee | 2) | | | | | | | | | |
| Contingent: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured of the Group Plan. SIGNATURE OF INSURED SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY) DATE ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | Contingent: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY) DATE ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/Or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed The NAME of the BENEFICIARY has been changed New Employee | , | | | Date of Birth | Relationship | 0 | Social Security # | % | | |
| Contingent: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured of the Group Plan. SIGNATURE OF INSURED SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY) DATE ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | Contingent: 1) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY) DATE ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/Or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed The NAME of the BENEFICIARY has been changed New Employee | | | | | | | | | | |
| Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured provided herein. If no designated beneficiary survives the Insured provided herein. If no designated beneficiary survives the Insured herein beneficiary survives the Insured provided herein. If no designated beneficiary survives the Insured provided herein. If no designated beneficiary survives the Insured herein beneficiary survives the Insured provided herein. If no designated beneficiary survives the Insured provided herein. If no designated beneficiary survives the Insured Beneficiary sur | Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY) DATE ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed | | Address | | | | | | | | |
| Address 2) Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured provided herein. If no designated beneficiary survives the Insured provided herein. If no designated beneficiary survives the Insured herein beneficiary survives the Insured provided herein. If no designated beneficiary survives the Insured provided herein. If no designated beneficiary survives the Insured herein beneficiary survives the Insured provided herein. If no designated beneficiary survives the Insured provided herein. If no designated beneficiary survives the Insured Beneficiary sur | Name Date of Birth Relationship Social Security # % Address 2) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY) DATE ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed | Contingent: | 1) | | | | | | | | |
| 2) Name Date of Birth Relationship Social Security # Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY) DATE ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | 2) Name Date of Birth Relationship Date of Birth Relationship Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured Plan. If no designated beneficiary survives the Insured Plan. If no designated beneficiary survives the Insured Plan. If no designated beneficiary survives provided herein. If no designated herein. If no designated | Contingent. | | | Date of Birth | Relationship | 0 | Social Security # | % | | |
| 2) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY) DATE ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | 2) Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, unless otherwise provided in the Group Plan. If no (NOW IS) SIGNATURE OF INSURED ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed The NAME of the BENEFICIARY has been changed New Employee | | | | | | | · | | | |
| Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY) DATE ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | Name Date of Birth Relationship Social Security # % Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY) ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed New Employee | | Address | | | | | | | | |
| If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | Address If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY) DATE ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed New Employee | | 2) | | | | | | | | |
| If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE SIGNATURE OF INSURED ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY) DATE ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed The NAME of the BENEFICIARY has been changed New Employee | | Name | | Date of Birth | Relationship | 0 | Social Security # | % | | |
| If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE SIGNATURE OF INSURED ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY) DATE ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed The NAME of the BENEFICIARY has been changed New Employee | | | | | | | | | | |
| equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE SIGNATURE OF INSURED ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED | | Address | | | | | | | | |
| equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE SIGNATURE OF INSURED ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan. SIGNATURE OF INSURED | If more than | one primary and/or contingent Ber | neficiary is designa | ated and no perd | entage has be | en designated, s | ettlement will b | e made in | | |
| ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE TO (NOW IS) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) TO (NOW IS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed The NAME of the BENEFICIARY has been changed New Employee | | | | | | | | | | |
| ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | ALL SIGNATURES MUST BE IN INK CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed The NAME of the BENEFICIARY has been changed New Employee | survives the | Insured, settlement will be made to | o the estate of the | Insured, unless | otherwise prov | vided in the Group | p Plan. | | | |
| CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE DATE DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed The NAME of the BENEFICIARY has been changed New Employee | SIGNATURE OF I | NSURED | SIGNATU | IRE OF WITNESS (SOM | EONE OTHER THAN | I BENEFICIARY) | DATE | | | |
| CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE DATE DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed The NAME of the BENEFICIARY has been changed New Employee | | | | | | | | | | |
| CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | CHANGE IN BENEFICIARY'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE DATE DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed The NAME of the BENEFICIARY has been changed New Employee | | | <u> </u> | | | | l . | | | |
| CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) TO (NOW IS) SOCIAL SECURITY # DATE DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | TO (NOW IS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed | | | ALL SIGNAT | URES MUST BE | IN INK | | | | | |
| CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) TO (NOW IS) SOCIAL SECURITY # DATE DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | TO (NOW IS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed | | | | | | | | | | |
| CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) TO (NOW IS) SOCIAL SECURITY # DATE DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | TO (NOW IS) TO (NOW IS) SOCIAL SECURITY # DATE CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SOCIAL SECURITY # DATE DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed | CHANGE IN | BENEFICIARY'S NAME (Comple | ete only if the nam | ne has been lega | lly changed) | | | | | |
| CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) TO (NOW IS) SIGNATURE OF INSURED ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | CHANGE IN INSURED'S NAME (Complete only if the name has been legally changed.) FROM (WAS) SIGNATURE OF INSURED TO (NOW IS) DATE DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed The NAME of the BENEFICIARY has been changed New Employee | | | • | | .y c.i.a.i.gca.i | SOCIAL SECURITY # | DATE | | | |
| FROM (WAS) SIGNATURE OF INSURED TO (NOW IS) SOCIAL SECURITY # DATE DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed | · ···o··· (·····o) | | | | | 0001112 020011111 11 | 57.11.2 | | | |
| FROM (WAS) SIGNATURE OF INSURED TO (NOW IS) SOCIAL SECURITY # DATE DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed | OLIANIOEIN | I INCLIDED IO NAME (O | 1 '64 | | | | | | | |
| SIGNATURE OF INSURED DATE ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed The NAME of the BENEFICIARY has been changed New Employee | | I INSURED'S NAME (Complete or | • | s been legally ch | anged.) | DOOLAL OF OUR TY # | DATE | | | |
| ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed | FROM (WAS) | | TO (NOW IS) | | | SOCIAL SECURITY # | DATE | | | |
| ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD | ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed | | | | | | | | | | |
| | THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed The NAME of the BENEFICIARY has been changed New Employee | SIGNATURE OF I | NSURED | | | | | DATE | | | |
| | THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed The NAME of the BENEFICIARY has been changed New Employee | | | | | | | | | | |
| | THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed The NAME of the BENEFICIARY has been changed New Employee | | | | | | | | | | |
| | THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed | ANY C | | | | | | THE GROUP | FIELD | | |
| SUPPORT DEPARTMENT ON THE APPROPRIATE FORM | This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed | | SUPPC | RT DEPARTMEN | NT ON THE APP | ROPRIATE F | ORM | | | | |
| | This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. The BENEFICIARY has been changed The NAME of the BENEFICIARY has been changed New Employee | | | | | | | | | | |
| THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY. | ☐ The BENEFICIARY has been changed ☐ The NAME of the BENEFICIARY has been changed ☐ New Employee | | | | | | | | | | |
| This is to certify that the following changes have been recorded in connection with the insurance for the above named insured. | ☐ The BENEFICIARY has been changed ☐ The NAME of the BENEFICIARY has been changed ☐ New Employee | | | | | | | | | | |
| | | | | | | | | | | | |
| T THE DENETIONED HAS DEED CHANGED. THE DENEME DENETIONER THAS DEED COADGED. THINEW EMPHOYAGE THE | Described by | ☐ THE BEN | iEFICIANT Has been changed | ☐ THE NAIVIE 0 | UIE DENEFICIA | in i nas been | criangeu _ | ı ivew ⊏inbioy | 56 | | |
| | Recorded by Date | | | | | | | | | | |
| | | | | | | | | | | | |