



**Group Insurance Beneficiary Form**

Please fill out Sections 1-6 for personal information on the employee.

1. Employee's Full Name		Date of Birth (Month/Day/Yr.)	
Address (Including City, State & Zip Code)		Group Number	
2. Name of Employer	Employee Job Title	Full-Time Employment (Month/Day/Yr.)	Hours Worked Per Week
3. Male <input type="checkbox"/> Female <input type="checkbox"/>	4. Social Security Number	5. Gross Monthly Salary	

**Your primary beneficiary will receive your death benefit in the event of your death.  
 The contingent beneficiary will receive your death benefit if the primary beneficiary is no longer living.**

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
6. Employee Life Insurance.....	<input type="checkbox"/>	<input type="checkbox"/>	Short Term Disability Insurance.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Dependent Life Insurance.....	<input type="checkbox"/>	<input type="checkbox"/>	Additional Buy-Up STD Plan .....	<input type="checkbox"/>	<input type="checkbox"/>
Number of Eligible Dependents Including Spouse _____			Long Term Disability Insurance.....	<input type="checkbox"/>	<input type="checkbox"/>
Supplemental/Voluntary Group Life Insurance....	<input type="checkbox"/>	<input type="checkbox"/>	Additional Buy-Up LTD Plan .....	<input type="checkbox"/>	<input type="checkbox"/>
Voluntary Accidental Death & Dismemberment ..	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Employee Only					
<input type="checkbox"/> Family					
Amount Requested \$ _____					

(\$10,000 increments to a max of \$300,000)

**NOTE: EVIDENCE OF INSURABILITY MAY BE REQUIRED.**

7. Primary Beneficiary's Last Name	First	Middle Initial	Relationship to You
Full Address of Beneficiary			Phone
Contingent Beneficiary's Last Name	First	Middle Initial	Relationship to You
Full Address of Contingent Beneficiary			Phone

**8. Unless otherwise provided herein, Beneficiaries designated to share proceeds shall share equally and the share of any Beneficiary who does not survive me shall be paid to the Contingent Beneficiary. If no Beneficiary survives me, the payment shall be made according to the terms of the policy, subject to revocation by me by written notice to my employer. I request the insurance provided by my employer's group insurance plan(s), and authorize the required deduction, (if any) from my wages.**

United Heritage Life Insurance Company assumes no responsibility for the beneficiary designation complying with any community property laws relating to the designation. Community property states include: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin.

Date Signed \_\_\_\_\_ Employee Signature \_\_\_\_\_