



Underwritten by
 United of Omaha Life Insurance Company
 Mutual of Omaha Insurance Company
 Mutual of Omaha Affiliates

3300 Mutual of Omaha Plaza
 Omaha, NE 68175-0001
 Toll Free (800) 877-5176
 Fax (402) 997-1865

Designation of Beneficiary Form

Employer/Group Section (To be completed by the employer/plan administrator. Required fields are marked with an asterisk(*).)

*Employer/Group Name: _____ Group ID: _____

Employee/Member Section (Please print clearly. Required fields are marked with an asterisk(*).)

*Last Name: _____ *First Name: _____ MI: _____

*Social Security Number: _____ *Birth Date (MM/DD/YYYY): _____ *Gender: _____ *Marital Status: _____

*Street Address: _____ Email Address: _____

*City: _____ *State: _____ *ZIP Code: _____ Telephone: () _____

Beneficiary for Death Benefits (Right to change beneficiary is reserved to the insured.)

Subject to the terms of the group contract(s), between Mutual of Omaha or a company affiliated with Mutual of Omaha and said employer, I request that the following beneficiary (beneficiaries) be substituted under said contract(s) as my designated beneficiary (beneficiaries), in lieu of any and all beneficiaries previously named by me.

If more than one beneficiary is named, the beneficiaries shall share benefits equally unless otherwise stated below. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Unless otherwise expressly provided, if any beneficiary designated below predeceases me, the share which such beneficiary would have received if such beneficiary had survived me shall be payable equally to the remaining designated beneficiary or beneficiaries. If no designated beneficiary survives me, the beneficiary shall be determined as prescribed in the group contract(s).

Primary Beneficiary Designation-Employer Paid Coverage

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Benefit Percentage (%)
Percentage Total:					100%

Secondary Beneficiary Designation-Employer Paid Coverage

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Benefit Percentage (%)
Percentage Total:					100%