Enrollment Confirmation
Benefit Designation

Insured and/or Administered by
Connecticut General Life Insurance Company
Hartford, CT 06152

CIGNA

Name of Insured: _____ Social Security Number: _____

Group Policyholder or
Participating Employer: **MICHIGAN EDUCATION SPECIAL SERVICES ASSOC.**
EMPLOYER, ASSOCIATION, UNION, ETC.

Group Policy Numbers:
G-57200 and G-57220

CIGNA is hereby requested to change my designation of beneficiary so that any amount payable at my death shall be payable as set forth in the paragraph checked below and subject to the General Provisions on the reverse side hereof *(complete only one section).* If sections 1, 2, 3 or 4 are completed, **the name, address, and relationship of each beneficiary,** including the name, address, and relationship of each current child named as a class in section 1 and 2 **must be provided on the back of this form.** If beneficiary is not related also provide date of birth and Social Security number.

1. ☐ Children of insured	To such of my children, including children by legal adoption, as shall be living at my death.
2. ☐ Wife or husband; otherwise, children of insured *(Check additional box if payment is to be made, per stirpes, to descendants.)*	To_____ my spouse, if living at my death; if not, then to such of my then living children, including children by legal adoption. ☐ The share of a deceased child shall be payable, per stirpes, to any living descendants *(including descendants through legal adoption)* of said child.
3. ☐ One or more primary beneficiaries	Equally to such of the following persons as are living at my death _____ *Insert names and relationship, if not related; see General Provision B on the other side of this form.*
4. ☐ One or more primary beneficiaries; otherwise, one or more secondary beneficiaries	Equally to such of the following persons as are living at my death _____ *Insert names and relationship, if not related; see General Provision B on the other side of this form.* If no such beneficiary be then living, equally to such of the following named persons as are then living _____ *Insert names and relationship, if not related; see General Provision B on the other side of this form.*
5. ☐ Trustee under trust agreement	To_____ *Name of trustee* of _____, or successor, as City State Zip trustee under a trust agreement of _____ *Name of settlor, grantor, donor* dated_____, as amended_____.
6. ☐ Trustee under will	To the trustee under my last will and testament, including any codicil thereto.
7. ☐ Estate of insured	To the executors or administrators of my estate.

NOTE: CIGNA is not and shall not be deemed a party to any agreement between an Employer and the insured and the receipt and recording of this Request by CIGNA and shall be subject to, but in no way alter, any and all terms, conditions, and provisions of any Participation Agreement and the Group Policy.

Date:_____ Signature of Insured: _____

Print Name of Insured: _____

Date:_____ Received and recorded by: _____

FOR USE OF HOME OFFICE OR ADMINISTRATION ONLY

This applies to all Life Insurance policies with CIGNA unless directed otherwise by the MESSA member.

General Provisions

A. If two or more beneficiaries who are natural persons taking in their own right are designated to receive payment as a class and if more than one shall be living, payment to such beneficiaries will be made in equal shares.

B. If any beneficiary named under section 3 or 4 on the other hereof is not related to the insured, CIGNA should be furnished with permanent identifying information including address, dates of birth, and Social Security number.

C. If there shall be no beneficiary entitled to payment as provided in the section selected, payment will be made to the spouse of the insured, if living; otherwise, in equal shares to the then living children of the insured, if any; or, if none, to the father and mother of the insured, share and share alike or to the survivor of them or, if none; then to the executors or administrators of the insured's estate.

D. CIGNA will make payment to the trustee under the insured's last will and testament if CIGNA shall receive at its home office, within a period of one year after the date of death of insured, evidence satisfactory to it that said trustee is authorized to receive payment under applicable law. If no evidence is received within said period of one year, payment will be made to the executors or administrators of the insured's estate.

E. Payment to any trustee in accordance with the terms hereof will discharge CIGNA to the extent of such payment, and CIGNA will not be responsible for the proper discharge of the trust or any of its terms.

Provide the name, relationship, and address of each beneficiary named in section 1, 2, 3 or 4 on the other side of this form.

Name: _____

Address: _____

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Relationship: _____

Name: _____

Address: _____

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Relationship: _____

Name: _____

Address: _____

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Relationship: _____

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