

**Instructions:** Please complete, sign and date this form to designate your beneficiary(ies) or to change your existing beneficiary(ies). This form cancels all prior designations. If more than one beneficiary is named and no percentages are indicated, payment will be made to them in equal shares. If there are more than two (2) primary and/or contingent beneficiaries, please attach a separate sheet of paper.

**PART 1: Information About You**

Name (Last Name, Suffix, First Name, MI)	Social Security Number <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> - <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px;"></div>
Address (Street, City, State, Zip)	Telephone Number

  

Billing Number	Billing Number
<div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px;"></div>

**PART 2: Primary Beneficiary (ies)**

I choose the person(s) named below to be the primary beneficiary(ies) of the Life Insurance benefits that may be payable at the time of my death. If any primary beneficiary(ies) is disqualified or dies before me, his/her percentage of this benefit will be paid to the remaining primary beneficiary(ies).

1. Name: \_\_\_\_\_  
 Street: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Telephone: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Email address: \_\_\_\_\_  
 Percentage: \_\_\_\_\_ (Total must equal 100% between all primary beneficiaries)
2. Name: \_\_\_\_\_  
 Street: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Telephone: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Email address: \_\_\_\_\_  
 Percentage: \_\_\_\_\_ (Total must equal 100% between all primary beneficiaries)

**PART 3: Contingent Beneficiary (ies)**

If all primary beneficiaries are disqualified or die before me, I choose the person(s) named below to be my contingent beneficiary(ies).

1. Name: \_\_\_\_\_  
 Street: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Telephone: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Email address: \_\_\_\_\_  
 Percentage: \_\_\_\_\_ (Total must equal 100% between all contingent beneficiaries)
2. Name: \_\_\_\_\_  
 Street: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Telephone: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Email address: \_\_\_\_\_  
 Percentage: \_\_\_\_\_ (Total must equal 100% between all contingent beneficiaries)

**PART 4: Signature**

**X** \_\_\_\_\_  
**Signature** **Date** \_\_\_\_\_

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