Designation of Beneficiary

Should you need to change your beneficiary information, please complete this form and return it to the benefits office at BOCES.

US Employee Benefits Services Group

Mutual of Omaha

Designation of Beneficiary

Companion Life Insurance Company
A Mutual *of* Omaha Company

Name of Employer: _____

Group Contract No(s): _____

Name of Insured Member: _____

Insured Member's Social Security Number: _____

Insured Member's Designation of Beneficiary

Subject to the terms of the above Group Contract(s), between **Companion Life Insurance Company** and said policyholder, 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:

Primary Beneficiary Designation

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

Secondary Beneficiary Designation

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

*If more than one named, the beneficiaries shall share equally unless otherwise stated above.

Unless otherwise above expressly provided, if any beneficiary listed above designated 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 any, who survived me, but if no designated beneficiary survives me, the beneficiary shall be determined as prescribed in said Group Contract(s).

If this Designation of Beneficiary refers only to a Group Life Insurance contract and if I am insured also under a Group Death and Dismemberment insurance contract issued by Mutual of Omaha Insurance Company, this designation shall apply to both contracts unless I made a separate designation on or after the date of this designation.

This Designation of Beneficiary is subject to change as provided in said Group Contract(s).

WITNESS _____ _____
Signature of Insured Member

Date of Insured Member's Signature _____

Return original to employer or policy administrator.

Acknowledgment

The above beneficiary designation has been recorded by policyholder on behalf of insurer. A copy of this designation is being returned for your records.

Date Recorded _____ _____
Signed by Benefits Manager for the Policyholder

Instructions

1. If a mistake is made, no erasures or corrections should be attempted, but a new form should be used.
2. If a married woman is to be named, her full given name should be shown — for example: Mary J. Smith, not Mrs. John H. Smith. Likewise, if the card is to be signed by a married woman, she should sign her given name.
3. When two or more beneficiaries are to be named and they are not to share equally, the percentage each beneficiary is to receive should be shown; dollars and cents should not be specified.
4. If there are any questions, you should consult the person handling the group insurance at your policyholder's office.