

Request for Change of Beneficiary



Group Office no. _____ Group policy no. _____ Participation no. _____ Account no. _____ Cert. no. _____

Group policyholder or participating employer _____
EMPLOYER, ASSOCIATION, UNION, ETC.

Name of insured _____ Former name _____
(IF APPLICABLE)

Fortis Benefits Insurance Company 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 sections 1 and 2 must be provided on page 2 of this form. If beneficiary is not related, also provide date of birth and social security number.

1. <input type="checkbox"/> Children of insured <input type="checkbox"/> <i>(Check additional box if payment is to be made, per stirpes, to descendants.)</i>	To such of my children, including children by legal adoption, as shall be living at my death. The share of a deceased child shall be payable, per stirpes, to any living descendants <i>(including descendants through legal adoptions)</i> of said child.
2. <input type="checkbox"/> Wife or husband; otherwise, children of insured <input type="checkbox"/> <i>(Check additional box if payment is to be made, per stirpes, to descendants.)</i>	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 <i>(including descendants through legal adoption)</i> of said child.
3. <input type="checkbox"/> One or more primary beneficiaries	Equally to such of the following named person(s) as are living at my death _____ <small>INSERT NAME(S) AND RELATIONSHIP(S). IF NOT RELATED, SEE GENERAL PROVISION B.</small>
4. <input type="checkbox"/> One or more primary beneficiaries; otherwise, one or more secondary beneficiaries	Equally to such of the following named person(s) as are living at my death _____ <small>INSERT NAME(S) AND RELATIONSHIP(S). IF NOT RELATED, SEE GENERAL PROVISION B.</small> If no such beneficiary be then living, equally to such of the following named persons as are then living. _____ <small>INSERT NAME(S) AND RELATIONSHIP(S). IF NOT RELATED, SEE GENERAL PROVISION B.</small>
5. <input type="checkbox"/> Trustee under trust agreement	To _____ <small>NAME OF TRUSTEE</small> of _____, or successor, <small>CITY STATE</small> as trustee under a trust agreement of _____ <small>NAME OF SETTLOR, GRANTOR, DONOR</small> dated _____, as amended.
6. <input type="checkbox"/> Trustee under will	_____ To the trustee under my last will and testament, including any codicil thereto
7. <input type="checkbox"/> Estate of insured	_____ To the executors or administrators of my estate
<input type="checkbox"/> Common Disaster or Limited Survivorship Clause <i>(May be checked only if section 1, 2, 3 or 4 above is completed.)</i>	The foregoing provisions and all rights of any person thereunder are subject to the following: If the Company shall receive at its home office within 90 days after my death, due proof any beneficiary survived me by less than 30 days, then any part of the proceeds which remains unpaid at the time such proof is received will be paid as if such beneficiary also predeceased me.

Note: Fortis Benefits Insurance Company is not and shall not be deemed a part to any agreement between an Employer and the insured and the receipt and recording of this Request by the Company 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 _____

Date _____ Received and recorded by _____

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 side hereof is not related to the insured, the Company should be furnished with permanent identifying information including address, date 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. The Company will make payment to the trustee under the insured's last will and testament if the Company 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 the Company to the extent of such payment, and the Company will not be responsible for the proper discharge of the trust or any of its terms.

Please provide the name, relationship and address of **each** beneficiary named in section 1, 2, 3 or 4 on the reverse side of this form.

Name _____

Address _____

Relationship _____

Name _____

Address _____

Relationship _____

Name _____

Address _____

Relationship _____

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