BENEFICIARY DESIGNATION

☐ Initial Beneficiary Designation(s) OR ☐ Change of all prior beneficiary designation(s) (*check only one box*), I hereby revoke any previous beneficiary designation(s), if any, for my group life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group or employer and direct that the insurance proceeds payable under the policy be paid as indicated below.

Employee Name	Social Security Number XXX XX ☐☐☐☐
Employee Address: Street City State Zip Code	Telephone Number ( )
Policyholder/Employer **University Hospitals Health System**	Policy/Employer Number **044252**

NAMING YOUR GROUP LIFE BENEFICIARY

It is important that your beneficiary designation be clear so that there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies) please indicate their full name, address, social security number (optional), and relationship. If the beneficiary is not related either by blood or marriage, insert the words "Not Related." If more than one primary or contingent beneficiary is named without a percentage indicated, the proceeds will be divided equally. Below you will find examples of common beneficiary designation. If you need assistance, contact the HR Service Center at **1-877-471-7522** or your own legal counsel.

Following are examples of the most common beneficiary designations:

Mary J. Doe, Wife (not Mrs. John Doe).

Mary J. Doe, Wife, if living, otherwise to Joseph W. Doe, Son.

Mary J. Doe, Wife, if living, otherwise to Jane Doe, Daughter, and Joseph W. Doe, Son in equal shares, if they are both living, otherwise to whichever of them survive me.

University Hospitals Health System (or one of its affiliates).

Estate of the Insured.

If you name more than one beneficiary with unequal shares, please show the percent of insurance to be paid to each beneficiary, for example "33 1/3% to Mary Jones, Mother and 66 2/3% to Edith Jones, Wife."

Beneficiary Designation Forms cannot be signed by a Power of Attorney.

To make changes to your beneficiary information, complete the reverse side of this form.

PRIMARY BENEFICIARY(IES) A primary beneficiary is the beneficiary or beneficiaries that you name to receive the benefits if they are living at the time of your death. The primary beneficiaries are the first in line to receive death benefits.				
Name:			Date of Birth:	
Address:	Street	City	State	Zip Code
Social Security Number: (optional) XXX-XX-☐☐☐☐	Relationship:			Benefit Percent:
Name:			Date of Birth:	
Address:	Street	City	State	Zip Code
Social Security Number: (optional) XXX-XX-☐☐☐☐	Relationship:			Benefit Percent:
Name:			Date of Birth:	
Address:	Street	City	State	Zip Code
Social Security Number: (optional) XXX-XX-☐☐☐☐	Relationship:			Benefit Percent:

CONTINGENT BENEFICIARY(IES) A contingent beneficiary, or secondary beneficiary, is the beneficiary or beneficiaries named to receive the insurance proceeds if no primary beneficiary mentioned above is alive at the time of your death.				
Name:			Date of Birth:	
Address:	Street	City	State	Zip Code
Social Security Number: (optional) XXX-XX-☐☐☐☐	Relationship:			Benefit Percent:
Name:			Date of Birth:	
Address:	Street	City	State	Zip Code
Social Security Number: (optional) XXX-XX-☐☐☐☐	Relationship:			Benefit Percent:
Name:			Date of Birth:	
Address:	Street	City	State	Zip Code
Social Security Number: (optional) XXX-XX-☐☐☐☐	Relationship:			Benefit Percent:

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies). **Signature of Employee:**	**Date:**

This form is invalid if not signed.

Return the completed form to University Hospitals, MSC – HR Services, 3605 Warrensville Center Road, Shaker Heights, Ohio 44122