



**BENEFICIARY DESIGNATION FORM**  
**GROUP LIFE AND GROUP ACCIDENTAL DEATH**  
**& DISMEMBERMENT INSURANCE**

First Unum Life Insurance Company  
Provident Life and Casualty Insurance Company  
The Paul Revere Life Insurance Company

**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 three (3) primary and/or contingent beneficiaries, please attach a separate sheet of paper. **Return the completed form to your employer.**

**SECTION 1: Employee Information**

Name (Last Name, Suffix, First Name, MI)	Social Security Number
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Employer Name	Check the coverages listed below to which this beneficiary designation applies: <input type="checkbox"/> Basic Life <input type="checkbox"/> Supplemental Life <input type="checkbox"/> AD&D <input type="checkbox"/> All
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**SECTION 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).

Name & Address	Relationship	Social Security Number	Date of Birth	Percentage
				<b>Total Must Equal 100%</b>

**SECTION 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).

Name & Address	Relationship	Social Security Number	Date of Birth	Percentage
				<b>Total Must Equal 100%</b>

**SECTION 4: Signature**

**X**

**Employee Signature**

**Date**

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

CS-1110-NY (12/09)

PLEASE PRINT - MUST BE FILLED IN WITH INK

(LAST NAME)

(FIRST NAME)

NO.	STREET
1	100
2	200
3	300
4	400
5	500
6	600
7	700
8	800
9	900
10	1000
11	1100
12	1200
13	1300
14	1400
15	1500
16	1600
17	1700
18	1800
19	1900
20	2000
21	2100
22	2200
23	2300
24	2400
25	2500
26	2600
27	2700
28	2800
29	2900
30	3000
31	3100
32	3200
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34	3400
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36	3600
37	3700
38	3800
39	3900
40	4000
41	4100
42	4200
43	4300
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45	4500
46	4600
47	4700
48	4800
49	4900
50	5000
51	5100
52	5200
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61	6100
62	6200
63	6300
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66	6600
67	6700
68	6800
69	6900
70	7000
71	7100
72	7200
73	7300
74	7400
75	7500
76	7600
77	7700
78	7800
79	7900
80	8000
81	8100
82	8200
83	8300
84	8400
85	8500
86	8600
87	8700
88	8800
89	8900
90	9000
91	9100
92	9200
93	9300
94	9400
95	9500
96	9600
97	9700
98	9800
99	9900
100	10000

CITY OR BOROUGH

ZIP

STATE

4. WORK PHONE

**5. CELL PHONE**

7. BIRTHDATE      /      /     

8. SOC. SEC. NO.

1000 1000

☐ SINGLE ☐ MARRIED (WEDDING DATE \_\_\_\_\_)

☐ **WIDOWED** ☐

☐ LEGALLY SEPARATED

**START**

**\_TERMINATED**

NO.	STREET
1	1000
2	1000
3	1000
4	1000
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6	1000
7	1000
8	1000
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11	1000
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96	1000
97	1000
98	1000
99	1000
100	1000

CITY OR BOROUGH

ZIP

STATE

You may name one or more beneficiaries. Use full name such as Ann Smith not Mrs. John Smith. (If more space is needed, continued on the other side)

## RELATIONSHIP

**ADDRESS**

## RELATIONSHIP

**ADDRESS**

IF YOU HAVE NO DEPENDENTS WRITE NONE

LIST BELOW NAMES OF SPOUSE & UNMARRIED DEP. CHILDREN

### CHECK RELATIONSHIP

FULL NAME

**SPOUSE**

1

1

MONTH \_\_\_\_\_

DATE OF BIRTH

DA

YEAR

**If you need more space to list all dependent children, continue on back.**

**SIGNATURE**

(DO NOT PRINT)

\_\_\_\_\_ FUND

**DECLINATION OF COVERAGE**

**(DENTAL AND/OR VISION BENEFITS)**

Member Name Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Address \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

This is to acknowledge and certify that I am currently a covered member of the \_\_\_\_\_ ("Fund").

However, effective upon my signing of this form, I hereby decline and waive further coverage of the following Fund benefits for myself and any of my eligible dependent(s) currently enrolled in such benefits (please place a "check mark" below next to the benefits you wish to decline):

\_\_\_\_\_ **DENTAL BENEFITS**

\_\_\_\_\_ **VISION BENEFITS**

I hereby agree to indemnify and make whole the \_\_\_\_\_ Fund, its heirs and assigns against any and all liability and/or loss arising out of my request to decline and waive further coverage of these benefits for myself and any eligible dependents currently enrolled.

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Notary Public