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

Employer Name	Check the coverages listed below to which this beneficiary designation applies: ☐ Basic Life ☐ Supplemental Life ☐ AD&D ☐ All

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
				Total Must Equal 100%

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
				Total Must Equal 100%

SECTION 4: Signature

X _____ _____

Employee Signature **Date**

DESIGNATION OF BENEFICIARY FUND OFFICE RECORD CARD

PLEASE PRINT – MUST BE FILLED IN WITH INK

1. MEMBER's FULL NAME _____
(LAST NAME) (FIRST NAME)

2. ADDRESS _____
NO. STREET CITY OR BOROUGH ZIP STATE

3. HOME PHONE _____ 4. WORK PHONE _____ 5. CELL PHONE _____

6. E-MAIL _____ 7. BIRTHDATE ___/___/_____ 8. SOC. SEC. NO. _____--_____--_____

9. CHECK ONE: ☐ SINGLE ☐ MARRIED (WEDDING DATE _____) ☐ WIDOWED ☐ DIVORCED ☐ LEGALLY SEPARATED

10. EMPLOYER NAME _____ START _____ TERMINATED _____

11. ADDRESS _____
NO. STREET 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)

NAME OF PRIMARY BENEFICIARY _____ RELATIONSHIP _____

ADDRESS _____

NAME OF CONTINGENT BENEFICIARY _____ RELATIONSHIP _____

ADDRESS _____

IF YOU HAVE NO DEPENDENTS WRITE NONE

LIST BELOW NAMES OF SPOUSE & UNMARRIED DEP. CHILDREN	CHECK RELATIONSHIP				DATE OF BIRTH		
FULL NAME	SPOUSE	DEPENDENT	M	F	MONTH	DAY	YEAR

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

DATE _____ 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