QualChoice® HEALTH INSURANCE

Designation of Beneficiary

Please complete and return signed original to your group plan administrator. KEEP A COPY FOR YOUR RECORDS.

Section I: Employee Information

Insured Name (Last, First, MI)	Social Security Number	QualChoice ID Number
Employer Name		Group Policy Number

Subject to the terms of the above Group Policy, I request that any sum payable by reason of my death be payable to the beneficiary(ies) listed in Section II.

It is my understanding that this designation cancels all previous designations of beneficiary and all elections of optional methods of settlement made by me under said policy(ies). If this Designation of Beneficiary refers only to a Group Life Insurance Policy and I am also insured for supplemental and/or group accidental death coverage, this designation also applies to those coverages.

Section II: Life Beneficiary Information

The total must equal 100%.
NOTE: Dependent life insurance benefits are payable to the employee or the employee's estate if the employee does not survive the dependent.

Beneficiary Name (Last, First, MI)	Relationship		Percentage ______________%
Address	City	State	Zip

Beneficiary Name (Last, First, MI)	Relationship		Percentage ______________%
Address	City	State	Zip

Beneficiary Name (Last, First, MI)	Relationship		Percentage ______________%
Address	City	State	Zip

Beneficiary Name (Last, First, MI)	Relationship		Percentage ______________%
Address	City	State	Zip

MUST TOTAL **100%**

Section III: Authorized Signature

You must sign this form in order for your designation(s) to become effective. Please keep a copy for your records. Return the signed original to your group plan administrator.

Employee Signature X	Date Signed (MM/DD/YYYY)