

Primary Beneficiary Designation Form

Accident Insurance

Name of Insured

Policy Number

Date of Birth

Primary Beneficiary Information

| Full Name | Relationship | Date of Birth | Percentage (%) |
|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

Total percentage must equal 100%.

Additional Instructions (optional)

Signature of Insured

Date

Please return completed form to your insurance carrier or plan administrator.