Group Life Insurance Beneficiary Designation Form

To be completed by the life insurance plan participant:

Your Full Name:____

Address (street, city, state, zip):____

Primary Life Insurance Beneficiary(ies):

Beneficiary's Full Name:____

Relationship to Plan Participant:______________________________Percent of Benefit Designated:_______%

Beneficiary's Address:____

Beneficiary's Full Name:____

Relationship to Plan Participant:______________________________Percent of Benefit Designated:_______%

Beneficiary's Address:____

Beneficiary's Full Name:____

Relationship to Plan Participant:______________________________Percent of Benefit Designated:_______%

Beneficiary's Address:____

Beneficiary's Full Name:____

Relationship to Plan Participant:______________________________Percent of Benefit Designated:_______%

Beneficiary's Address:____

I understand that when this completed form is returned to Human Resources, this life insurance beneficiary designation will supersede any prior life insurance beneficiary designations. In addition, unless I have provided written instructions to the contrary, this designation will also apply to any Business Accident Travel Insurance benefit for which I may be eligible.

Your Signature:____Date:_______________________

(over)

If you would like to designate a contingent life insurance beneficiary(ies), please complete and sign below. A benefit will be paid to your contingent beneficiary(ies) only if your primary beneficiary(ies) precedes you in death.

Contingent Life Insurance Beneficiary(ies): *(optional)*

Beneficiary's Full Name:____

Relationship to Plan Participant:______________________________Percent of Benefit Designated:______%

Beneficiary's Address:____

Beneficiary's Full Name:____

Relationship to Plan Participant:______________________________Percent of Benefit Designated:______%

Beneficiary's Address:____

Beneficiary's Full Name:____

Relationship to Plan Participant:______________________________Percent of Benefit Designated:______%

Beneficiary's Address:____

Beneficiary's Full Name:____

Relationship to Plan Participant:______________________________Percent of Benefit Designated:______%

Beneficiary's Address:____

Your Signature:____Date:______________________________

Please return this completed form to Human Resources, CSQ, Franklin & Marshall College, P.O. Box 3003, Lancaster, PA, 17604-3003, fax (717) 291-3969.