Life Insurance Enrollment

This is provided to all House Staff at no cost.

1. Please fill out as completely as you feel necessary. **At least one beneficiary must be listed.**
2. Print out and **SIGN & DATE** at the bottom.

Please note this insurance is available to House Staff only, not your spouse or dependents. You MUST complete the UNUM enrollment form. If you do not have dependents to list as your beneficiary, you may select your parents, friends, etc.
Please fully complete this form and sign it if you wish to designate a beneficiary or if you want to change your existing beneficiary designation.

**SECTION 1: Employee's Information**

<table>
<thead>
<tr>
<th>Name (First, Middle Initial, Last)</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Name of current employer- Division</th>
<th>Policy Number (s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**SECTION 2: Primary Beneficiary (ies)**

I designate the person(s) named below as my primary beneficiary (ies) to receive payment under the policy in the event of my death. The share of any primary beneficiary who is no longer living or is otherwise disqualified by law at the time of my death, will pass to any remaining beneficiary (ies) in the order I designated.

1. Name
   Social Security Number
   Date of birth
   Relationship
   Address 1
   Address 2
   _____%  

2. Name
   Social Security Number
   Date of birth
   Relationship
   Address 1
   Address 2
   _____%  

3. Name
   Social Security Number
   Date of birth
   Relationship
   Address 1
   Address 2
   _____%  

**SECTION 3: Contingent Beneficiary (ies)**

I designate the person(s) below as my contingent beneficiary (ies) who will receive payment only if all primary beneficiary (ies) predecease me or are otherwise disqualified by law.

1. Name
   Social Security Number
   Date of birth
   Relationship
   Address 1
   Address 2
   _____%  

2. Name
   Social Security Number
   Date of birth
   Relationship
   Address 1
   Address 2
   _____%  

3. Name
   Social Security Number
   Date of birth
   Relationship
   Address 1
   Address 2
   _____%  

**SECTION 4: Authorization and Signatures**

By signing this document, I understand and agree to the following: This beneficiary designation revokes all prior designations. This beneficiary designation form will apply to my Unum Insurance plan established in connection with my employer's plan. If more than one primary beneficiary is named and no percentages are indicated, payment will be made in equal shares to my primary beneficiary (ies) who survive(s) me or if the percentages listed do not add up to 100%, Unum will disburse the benefit pursuant to its discretion and/or pursuant to the above policy provisions if applicable.

________________________________________  __________________________
Employee Signature                      Date

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