

Other Coverage - Please list any other insurance or government plan coverage for you and your dependent(s).

Last Name	First Name	Employer Name	Carrier	Policy #	Carrier Telephone #

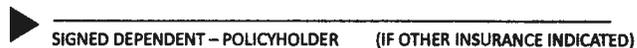
BENEFICIARY INFORMATION (For Life Benefit)

Name of Beneficiary (Example: Mary Ann Jones <i>not</i> Mrs. John Jones)	Address	Relationship
Additional Beneficiary	Address	

If more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiaries (or beneficiary) as survive the insured, unless otherwise provided herein. If no designated beneficiary survives, settlement will be made to the estate of the insured unless otherwise provided in the Group policy.

I HEREBY CERTIFY THE ABOVE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I AUTHORIZE THE RELEASE OF ANY FACTS CONCERNING THE INJURY, ILLNESS, OR TREATMENT OF MYSELF OR MY DEPENDENTS. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.





EMPLOYEE 'S SIGNATURE

SIGNED DEPENDENT - POLICYHOLDER (IF OTHER INSURANCE INDICATED)