

## CAPISTRANO UNIFIED SCHOOL DISTRICT

## District-Sponsored Group Life/Accidental Death and Disability Insurance Beneficiary Form

Policy Number: 91277

Company: UNUM

Employee Name (Please Print):				ONOM
Date of Birth: Social	Security Numbe	r:		
Date of Hire: Effective	re Date:			
<u>Primary Beneficiary 1</u> -Full Name and Address Name:	_	Date of Birth	Social Security Number	Relationship
Street:	City: _		State:	Zip:
(Or Name of Trust If Applicable)				
<b>Primary Beneficiary 2-Full Name and Address</b> Name:	_	Date of Birth	Social Security Number	Relationship
Street:			State:	Zip:
<u>Primary Beneficiary 3</u> -Full Name and Address Name:	_	Date of Birth	Social Security Number	Relationship
Street:			State:	Zip:
Contingent Beneficiary 1-Name and Address  Name:  Street:		Date of Birth	Social Security Number State:	Relationship  Zip:
Contingent Beneficiary 2-Name and Address	_	Date of Birth	Social Security Number	Relationship
Name: Street:			State:	Zip:
Contingent Beneficiary 3-Name and Address Name:	_	Date of Birth	Social Security Number	Relationship
Street:			State:	Zip:
<ul> <li>*Percentages must total 100%. If no percentages must total 100%. If no percentages</li> <li>This beneficiary designation revokes allowed the surviving beneficiaries of the same classing beneficiary (primary or contingentage)</li> </ul>	revocable prior beneficiary predeces (primary or cont	peneficiary designat ases you, that benef ingent).	ions. ficiary's share will be divided p	oro-rata among
Signature:	Date:			