VFIS®

Beneficiary Designation for Accident & Sickness Policy

Complete this block each time this form is used—Please Print

Name of Organization _____

Member's/Employee's Name _____

Member's Date of Birth _____ Date Member Joined Organization _____

Complete, sign and date this block if you wish to name or change your beneficiary.

I hereby designate the following beneficiary(ies) with respect to amounts payable as indemnity for loss of life under the referenced Accident & Sickness Policy and hereby revoke any designation of beneficiary thereunder heretofore made by me. I direct that any amounts payable under said Policy to my beneficiary(ies) named below be paid to those of Primary Beneficiary who survive me, otherwise to those surviving in Contingent Beneficiary, in proportion to the percentages listed.

Primary Beneficiary: Name _____ Relationship _____ Date of Birth _____ Share _____ %

Name _____ Relationship _____ Date of Birth _____ Share _____ %

Contingent Beneficiary: Name _____ Relationship _____ Date of Birth _____ Share _____ %

Name _____ Relationship _____ Date of Birth _____ Share _____ %

If none of the above-named beneficiaries are living at the time of my death, I direct that payment be made in accordance with the terms of the policy. I reserve the right to revoke or change this designation.

Signature _____ **Date** _____

This form should be retained in the files of your department or organization.

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Primary Beneficiary: Name _____ Relationship _____ Date of Birth _____ Share _____ %

Name _____ Relationship _____ Date of Birth _____ Share _____ %

Contingent Beneficiary: Name _____ Relationship _____ Date of Birth _____ Share _____ %

Name _____ Relationship _____ Date of Birth _____ Share _____ %

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