



New Change

PLEASE TYPE OR PRINT WITH BALLPOINT PEN.

| | | | | | |
|-------------------------|-------|----------------|---|----------------------------------|---|
| NAME OF EMPLOYEE — LAST | FIRST | MIDDLE INITIAL | SEX M <input type="checkbox"/> F <input type="checkbox"/> | DATE OF BIRTH MO / DAY / YEAR | DATE OF HIRE (FULL TIME) MO / DAY / YEAR |
|-------------------------|-------|----------------|---|----------------------------------|---|

SOCIAL SECURITY NO. (THIS IS YOUR CERTIFICATE NO.)

| | | |
|--|--------------------------|-------------------------------|
| EMPLOYER Employer's Resource Group Division # | GROUP NO. F001785-001 | AGENCY Service Agency Inc. |
|--|--------------------------|-------------------------------|

Irrevocable Beneficiary: Yes No **Note:** If you select irrevocable beneficiary, you may not change the beneficiary without the consent of the irrevocable beneficiary. An irrevocable beneficiary has a vested interest in the proceeds of the contract, therefore the contract holder cannot exercise certain rights without the permission of the irrevocable beneficiary.

If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. SEE BELOW FOR DETAILS.

| BENEFICIARY Must Be Completed | First Name | Last Name | Date of Birth | Social Security Number | Relationship | Benefit % |
|----------------------------------|------------|-----------|-----------------|------------------------|--------------|-----------|
| | Primary | | MO / DAY / YEAR | | | % |
| | Primary | | MO / DAY / YEAR | | | % |
| | Contingent | | MO / DAY / YEAR | | | % |
| | Contingent | | MO / DAY / YEAR | | | % |

WARNING: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties. (Not enforceable in Oregon or Virginia.)

SIGNATURE OF EMPLOYEE OR MEMBER _____

DATE SIGNED ____ / ____ / ____
MO DAY YEAR

| |
|---|
| FOR FDL USE ONLY Effective Date / / |
|---|

Important Note For Married Employees: If you reside in AZ, CA, ID, LA, NV, NM, TX, WA or WI, you may name someone other than your spouse as primary beneficiary. However, payment of benefits may be delayed or disputed unless your spouse consents to waive his or her rights to any community property interest in the benefits. We have provided below a "Spousal Consent for Community Property States" for your spouse's signature. **FORT DEARBORN WILL NOT BE LIABLE FOR DAMAGES DUE TO ANY DELAY OR DISPUTE IN PAYMENT OF BENEFITS IF YOU CHOOSE NOT TO OBTAIN YOUR SPOUSE'S SIGNATURE.**

Spousal Consent for Community Property States: I hereby consent to the Primary Beneficiary designated by my spouse. This consent supersedes any prior spousal consent I may have given under this plan.

Spouse Signature _____ Date _____ Employee has no legal spouse

Primary Beneficiary: The primary beneficiary is the person(s) you name to receive death benefits. You may name more than one beneficiary. *If you specify benefit percentages, the total must equal 100%.* If you do not specify benefit percentages, proceeds will be paid in equal shares to the primary beneficiaries who survive you.

Contingent Beneficiary: The contingent beneficiary is the person(s) you name to receive death benefits if no primary beneficiary survives you. *If you specify benefit percentages, the total must equal 100%.*

No Beneficiary: If you do not name a beneficiary, or if no beneficiary survives you, we will pay death benefits in the order of survivorship shown in your group certificate.