



READ BEFORE PROCEEDING



THE HARTFORD

BENEFICIARY DESIGNATION INSTRUCTIONS

Effective: July 1, 2019

Policy#681601

As a member of the recently awarded life administrator, The Hartford, please designate your primary beneficiary as well as a contingent beneficiary; if applicable.

What is a contingent beneficiary? A contingent beneficiary is a beneficiary utilized in the event the primary designated beneficiary is deceased, unable to be located, or refuses inheritance at the time benefits are to be paid. The named contingent beneficiary will receive and is entitled to your benefit.

Important:

- If you wish to designate separate beneficiaries for Basic Life insurance and Supplemental Life insurance, it is required to identify on the beneficiary designation form and complete one for each plan type. Indicate on the Beneficiary Designation form the line of coverage.

Example:

First Beneficiary Form – \$50K Basic Life

| PRIMARY BENEFICIARY(IES) | | | |
|--------------------------|----------------------------------|-------------------|----------------|
| Name: | Spouse Name | Date of Birth: | 08/12/2019 |
| Address: | 1234 Main St. Santa Fe, NM 87500 | Telephone Number: | (505) 000-0000 |
| Social Security Number: | 000-00-0000 | Relationship: | Spouse |
| | | Benefit Percent: | 100 % |

Second Beneficiary Form – Supplemental Life

| PRIMARY BENEFICIARY(IES) | | | |
|--------------------------|----------------------------------|-------------------|----------------|
| Name: | Child Name | Date of Birth: | 08/12/2019 |
| Address: | 1234 Main St. Santa Fe, NM 87500 | Telephone Number: | (505) 000-0000 |
| Social Security Number: | 000-00-0000 | Relationship: | Child |
| | | Benefit Percent: | 50 % |

| PRIMARY BENEFICIARY(IES) | | | |
|--------------------------|----------------------------------|-------------------|----------------|
| Name: | Child Name | Date of Birth: | 08/12/2019 |
| Address: | 1234 Main St. Santa Fe, NM 87500 | Telephone Number: | (505) 000-0000 |
| Social Security Number: | 000-00-0000 | Relationship: | Child |
| | | Benefit Percent: | 50 % |

Concluding Directions:

- Submit original Beneficiary Designation form(s) to the Agency Human Resource Administrator.
- Keep a copy for your personal records.
- Fax a copy to Erisa 505-244-6009

BENEFICIARY DESIGNATION FORM INSTRUCTIONS

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

The completion of this Beneficiary Form will revoke any previous beneficiary designation(s), if any, for your group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group/employer.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. The listed percentages must add up to 100%. Please provide all of the information requested. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your Company's benefits administrator or your own legal advisor.

A beneficiary for employee Life Insurance may be changed at any time upon written request.

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA).

Sample wording for common beneficiary designations are shown below:

Example #1:

| | | |
|----------|----------------------|--------------------------|
| Jane Doe | Relationship: Spouse | Benefit Percentage: 100% |
|----------|----------------------|--------------------------|

Example #2:

| | | |
|----------|----------------------|-------------------------|
| Jane Doe | Relationship: Spouse | Benefit Percentage: 50% |
|----------|----------------------|-------------------------|

| | | |
|-----------|------------------------|-------------------------|
| Susan Doe | Relationship: Daughter | Benefit Percentage: 25% |
|-----------|------------------------|-------------------------|

| | | |
|----------|-------------------|-------------------------|
| John Doe | Relationship: Son | Benefit Percentage: 25% |
|----------|-------------------|-------------------------|

If additional space is required, write, "See attached", on the beneficiary line on the beneficiary designation form and attach a separate sheet, listing all the required beneficiary information for each beneficiary listed. **This separate sheet should be signed by you (the Employee) and dated.**

BENEFICIARY DESIGNATION

Initial Beneficiary Designation(s) OR Change of all prior beneficiary designation(s) (*check only one box*), I hereby revoke any previous beneficiary designation(s), if any, for my group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group or employer and direct that the insurance proceeds payable under the policy be paid as indicated below.

| | | |
|------------------------|---------------------|--|
| Employee Name: | Employee ID Number: | Social Security Number: <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Employee Address: | | Telephone Number: |
| Policyholder/Employer: | | Policy Number: |

NAMING YOUR GROUP LIFE BENEFICIARY

It is important that your beneficiary designation be clear so there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. If you need assistance, contact your Company representative or your own legal counsel. Benefits payable for a Dependent's death are payable, where applicable, to you if living, otherwise, the insurer, at their option, may pay the benefit to your surviving spouse or to the executors or administrators of your estate.

PRIMARY BENEFICIARY(IES)

| | |
|---|--------------------------------|
| Name: _____ | Date of Birth: _____ |
| Address: _____ | Telephone Number: () _____ |
| Social Security Number: _____ Relationship: _____ | Benefit Percent: _____ % |
| | |
| Name: _____ | Date of Birth: _____ |
| Address: _____ | Telephone Number: () _____ |
| Social Security Number: _____ Relationship: _____ | Benefit Percent: _____ % |
| | |
| Name: _____ | Date of Birth: _____ |
| Address: _____ | Telephone Number: () _____ |
| Social Security Number: _____ Relationship: _____ | Benefit Percent: _____ % |

CONTINGENT BENEFICIARY(IES)

| | |
|---|--------------------------------|
| Name: _____ | Date of Birth: _____ |
| Address: _____ | Telephone Number: () _____ |
| Social Security Number: _____ Relationship: _____ | Benefit Percent: _____ % |
| | |
| Name: _____ | Date of Birth: _____ |
| Address: _____ | Telephone Number: () _____ |
| Social Security Number: _____ Relationship: _____ | Benefit Percent: _____ % |

Disclaimer: Spousal consent does not apply to ERISA plans.

Spousal Consent For Community Property States Only: If you live in a community property state - Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, or Wisconsin - you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details.

This will certify that, as spouse of the Employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life and/or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse: _____ **Date:** _____

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

Signature of Employee: _____ **Date:** _____

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA)