MERCER VOLUNTARY BENEFITS BENEFICIARY DESIGNATION FORM

*This form is to designate a beneficiary for life insurance coverage for you and your spouse. Remember: When designating the Primary, be sure that the total shares equal 100%. Your Contingent Beneficiary is the person who will receive the death benefit if your primary beneficiary is no longer living.

☐ Please check if new address

Owner Name_____ SSN#_____
Daytime Phone: (___)_____ Cert#_____
Address_____ City/State/Zip_____
Owner's Employer (or company insurance obtained from):_____

All previous beneficiary designations are hereby revoked and the following are designated as beneficiaries under this coverage. **No white outs or cross outs allowed in this section.**

Primary Beneficiary for Employee Coverage

Name: _____%Share_____ Relationship_____
Address: _____City/State/Zip_____
Date of Birth: _____ SSN#_____ Daytime Phone: (___)_____

Name: _____%Share_____ Relationship_____
Address: _____City/State/Zip_____
Date of Birth: _____ SSN#_____ Daytime Phone: (___)_____

Total _____% (must equal 100%)

Contingent Beneficiary for Employee Coverage (if Primary is not living)

Name: _____%Share_____ Relationship_____
Address: _____City/State/Zip_____
Date of Birth: _____ SSN#_____ Daytime Phone: (___)_____

Name: _____%Share_____ Relationship_____
Address: _____City/State/Zip_____
Date of Birth: _____ SSN#_____ Daytime Phone: (___)_____

Total _____ % (must equal 100%)

Primary Beneficiary for Spouse Coverage

Name: _____%Share_____ Relationship_____
Address: _____City/State/Zip_____
Date of Birth: _____ SSN#_____ Daytime Phone: (___)_____

Name: _____%Share_____ Relationship_____
Address: _____City/State/Zip_____
Date of Birth: _____ SSN#_____ Daytime Phone: (___)_____

Total _____ % (must equal 100%)

Contingent Beneficiary for Spouse Coverage (if Primary is not living)

Name: _____%Share_____ Relationship_____
Address: _____City/State/Zip_____
Date of Birth: _____ SSN#_____ Daytime Phone: (___)_____

Name: _____%Share_____ Relationship_____
Address: _____City/State/Zip_____
Date of Birth: _____ SSN#_____ Daytime Phone: (___)_____

Total _____ % (must equal 100%)

(The beneficiary for dependent children's coverage is the employee unless otherwise designated)

Community Property Laws- If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, and Wisconsin), and names someone other than your spouse as beneficiary, payment of benefits may be delayed or disputed unless your spouse also signs the beneficiary designation.

Spouse's Signature_____ Date _____

I represent the statements and answers given in this request form are true, complete, and correctly recorded to the best of my knowledge and belief. I understand the request for service will not become effective until received at Mercer Voluntary Benefits, and approved in accordance with the terms of the coverage.

Owner's Signature_____ Date _____

(Designations are invalid unless signature and date are completed)

Please send your signed change form to:
Mercer Voluntary Benefits
PO Box 9122
Des Moines, IA 50306-9279