MERCER VOLUNTARY BENEFITS DESIGNATION FORM

*This form is to designate a beneficiary for life insurance coverage for you and your spouse/domestic partner. Remember: When designating the Primary Beneficiary, 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: (____)_____ Certificate #_____
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, write overs, 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: (____)_____

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: (____)_____

Primary Beneficiary for Spouse/Domestic Partner 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: (____)_____

Contingent Beneficiary for Spouse/Domestic Partner 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: (____)_____

(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/domestic partner as beneficiary, payment of benefits may be delayed or disputed unless your spouse/domestic partner also signs the beneficiary designation.

Spouse/Domestic Partner'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, 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 50306-9122
Fax: (515) 365-1520

Instructions to the Employee:

1. Please complete all personal information. Name, SSN #, Certificate #, Full address and Phone Number.
2. Please complete the 'Primary Beneficiary for Employee Coverage' section:
    a. Beneficiary's Full Name
    b. % of share
    c. Relationship
    d. Date of Birth and/or SSN#
    e. Full address (optional)
    f. Phone Number (optional)
3. If more than one Primary Beneficiary is being listed, total shares **MUST** equal 100%. Only whole numbers are allowed and must equal 100%. Dollar amounts, fractions and decimals will not be accepted.
4. If more than 2 Primary Beneficiaries are being listed, please list all required information on a separate sheet in the same format as above. This sheet needs to be signed and dated.
5. If listing Contingent Beneficiaries, please use same format as Primary. Contingent Beneficiaries may **NOT** be the same as a Primary Beneficiary.
6. NO WHITE OUTS, WRITE OVERS, OR CROSS OUTS ALLOWED. Please request a new form if a correction is needed.
7. Please follow the same instructions for the 'Primary Beneficiary for Spouse/Domestic Partner Coverage' and 'Contingent Beneficiary for Spouse/Domestic Partner Coverage' sections when applicable.
8. When naming a Trust as Beneficiary, please include all of the following:
    a. Name of Trust
    b. Date Trust was established
    c. Address for Trust
    d. Attach a copy of the Trust (optional)
9. When naming a charity or non-profit as Beneficiary, please include all of the following:
    a. Name of Charity
    b. Full address
    c. Phone Number
    d. Contact Name (local branch)
10. When naming a funeral home as Beneficiary, please include all of the following:
    a. Name of Funeral home
    b. Full address
    c. Phone Number
    d. Share % you want to go to the Funeral home for expenses

The Customer Service Representatives of
Mercer Health & Benefits Administration LLC
Program Manager