

Dear BTA Member,

Please complete the attached *Beneficiary Designation Form for Group Life and Group Accident Insurance*. You **MUST** identify a beneficiary to ensure that the proper party receives the benefit. This \$25,000.00 benefit is provided to you at **no cost** by the BOCES Teacher's Association Benefits Trust. Please complete and return this form to:

BTA Benefits Trust Fund
PO BOX 566
WHITE PLAINS, NY 10602

Thank you,
Melissa Barreto
BTA Benefits Chairperson



Beneficiary Designation Form for Group Life and Group Accident Insurance

First Unum Life Insurance Company
Provident Life and Casualty Insurance Company
The Paul Revere Insurance Company

Please fully complete this form and sign it if you wish to designate a beneficiary or if you want to change your existing beneficiary designation.

Employee's Information:

Social Security Number

Name (First, Middle initial, Last)

Name of current employer- Division

Policy Number (s) *118 668-038*

Primary Beneficiary (ies):

I designate the person(s) named below as my primary beneficiary (ies) to receive payment under the policy in the event of my death. The share of any primary beneficiary who is no longer living or is otherwise disqualified by law at the time of my death, will pass to any remaining beneficiary (ies) in equal shares.

1. _____ %
Name / Social Security Number Date of birth Relationship Address
2. _____ %
Name / Social Security Number Date of birth Relationship Address
3. _____ %
Name / Social Security Number Date of birth Relationship Address

Contingent Beneficiary (ies):

I designate the person(s) below as my contingent beneficiary (ies) who will receive payment only if all primary beneficiary (ies) predecease me or are otherwise disqualified by law.

1. _____ %
Name / Social Security Number Date of birth Relationship Address
2. _____ %
Name / Social Security Number Date of birth Relationship Address
3. _____ %
Name / Social Security Number Date of birth Relationship Address

Authorization and Signatures:

By signing this document, I understand and agree to the following: This beneficiary designation revokes all prior designations. This beneficiary designation form will apply to my UnumProvident Insurance plan established in connection with my employer's plan. If more than one primary beneficiary is named and no percentages are indicated, payment will be made in equal shares to my primary beneficiary (ies) who survive(s) me or if the percentages listed do not add up to 100%, UnumProvident will disburse the benefit pursuant to its discretion and/or pursuant to the above policy provisions if applicable.

Employee Signature Date Witness Signature Date