Hartford Life Insurance
Group Life Insurance Beneficiary Designation

University of Delaware Policy Effective Date ___/___/___

Name (Please Print):______________________________ Employee ID#:____________________

It is important that your beneficiary designation be clear so that there will be no question as to your intent. It is also important that you name a primary and secondary beneficiary. When naming your beneficiary(ies) please indicate their full name, address, and relationship. If the beneficiary is not related either by blood or marriage, insert the words, "Not Related." If more than one primary or contingent beneficiary is named without a percentage indicated, the proceeds will be divided equally.

(check only one box)

[ ] Initial Beneficiary designation(s) or

[ ] Change of all prior beneficiary designation(s), 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 the University of Delaware and direct that the insurance proceeds payable under the policy be paid as indicated below.

Common Terms: My Children - the children born of any and all marriages or legally adopted at any time.
My Estate - my duly appointed executors or administrators.

Unless otherwise provided:

(a) if a class of Beneficiaries contains more than one person, the benefits due the Beneficiaries in such class at my death are to be apportioned in equal shares to the living Beneficiaries of the class;

(b) if all Beneficiaries predecease me, the benefits will be payable to my estate.

Some designations, such as Trusts. may require alternative documents which will be sent to you for completion.

Primary Beneficiary(ies)

1.) Name:______________________________ Date of Birth:____________________

Address:______________________________ Relationship:____________________

______________________________ Benefit Percentage:________________

2.) Name:______________________________ Date of Birth:____________________

Address:______________________________ Relationship:____________________

______________________________ Benefit Percentage:________________

Secondary Beneficiary(ies)

1.) Name:______________________________ Date of Birth:____________________

Address:______________________________ Relationship:____________________

______________________________ Benefit Percentage:________________

2.) Name:______________________________ Date of Birth:____________________

Address:______________________________ Relationship:____________________

______________________________ Benefit Percentage:________________

(Attach additional pages if more than two)

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

______________________________ ____________________

Employee Signature **Date**

Please return your completed form to the UD Office of Human Resources - Benefits

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