Arch
Insurance Group

Arch Insurance Company

Beneficiary Designation Form

Use this form to designate a beneficiary(ies) for your Accidental Loss of Life Benefit Amount. See page 2 for important information on choosing beneficiary(ies). Complete a new form if you want to designate a new or additional beneficiary(ies).

Insured Information

Insured Last Name _____ First Name _____ Middle Initial _____

Social Security Number _____ Daytime Telephone Number _____

Beneficiary Information

I am: (Please check appropriate box.)

☐ Designating a beneficiary(ies) for the first time ☐ Changing a previous designation

Primary Beneficiary(ies) Full Name (Last, First, MI)	Address	Birth Date	Social Security	Relationship to	Share %

Contingent Beneficiary(ies) Full Name (Last, First, MI)	Address	Birth Date	Social Security	Relationship to	Share %

Authorization

For the beneficiary designation(s) I have indicated, I understand that if one of my primary beneficiaries is not living when the benefit is paid, the amount will be divided equally among any remaining beneficiaries. I also understand that no amount will be paid to a contingent beneficiary as long as at least one of my primary beneficiaries is living. I understand that I must complete a new Beneficiary Designation Form if I want to change or revoke my beneficiary designation.

Insured Signature _____ Date _____

Please make a copy of this form for your records and return the original.

(over)

The Standard Life Insurance Company of New York

Enrollment and Change

To Be Completed By Human Resources

Group Number	Division	Billing Category	Date of Employment
445164			

To Be Completed By Applicant

☐ Apply for Coverage ☐ Beneficiary Change *Complete Beneficiary Section below.* ☐ Name Change

☐ Add or ☐ Delete Dependent Date of add/delete _____

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	☐ Male ☐ Female

Your Address	City	State	ZIP

Former Name (Last, First, Middle) *Complete only if name change*	Phone Number

Employer Name	Job Title/Occupation
Town of Oswego Fire District	

Hours Worked Per Week	Earnings $_____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year

Coverage ***Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.***

Life Insurance

☒ Life with AD&D (Employer Paid)

Beneficiary ***This designation applies to Life/Life with AD&D Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.***

Primary - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Contingent - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Signature I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Fraud Notice - Only applies to Accident and Health Insurance (AD&D/Disability/Dental): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance of statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Member/Employee Signature Required _____ Date (Mo/Day/Yr) _____

SERVICE AWARD PROGRAM

NAME OF VOLUNTEER _____

1ST BENEFICIARY/RELATIONSHIP _____

CONTINGENT BENEFICIARY/RELATIONSHIP _____

DATE _____ SIGNATURE _____

Offered by:

PROVIDENT

Beneficiary Designation Form

Group Accidental Death & Dismemberment Insurance

First Unum Life Insurance Company

For the members of:

FASNY Firemen's Association of the State of New York

Instructions: Please complete, sign and date this form to designate your beneficiary(ies) or to change your existing beneficiary(ies). This form cancels all prior designations. If more than one beneficiary is named and no percentages are indicated, payment will be made to them in equal shares. If there are more than three (3) primary and/or contingent beneficiaries, please attach a separate sheet of paper. **Return the completed form to Provident Agency, Inc. by fax to 412-963-0415 or by mail to 272 Alpha Drive, Pittsburgh, PA 15238.**

Section 1: Member Information

Name (Last Name, Suffix, First Name, MI)	FASNY ID #	Date of Birth

Address, City, State, Zip	Social Security Number

Section 2: Primary Beneficiary(ies)

I choose the person(s) named below to be the primary beneficiary(ies) of the Life Insurance benefits that may be payable at the time of my death. If any primary beneficiary(ies) is disqualified or dies before me, his/her percentage of this benefit will be paid to the remaining primary beneficiary(ies).

Name & Address	Relationship	Social Security Number	Date of Birth	Percentage

Total Must Equal 100%

Section 3: Contingent Beneficiary(ies)

If **all** primary beneficiaries are disqualified or die before me, I choose the person(s) named below to be my contingent beneficiary(ies) of the Life Insurance benefits that may be payable at the time of my death.

Name & Address	Relationship	Social Security Number	Date of Birth	Percentage

Total Must Equal 100%

Section 4: Signature

X _____

Member Signature

Date

PAI-400-1004 (05.2011)