Group Insurance Beneficiary Designation/Change

1. EMPLOYEE INFORMATION (please print)

Last Name	First Name	MI	Social Security #	Marital Status (check one) ☐ Married ☐ Widowed ☐ Single ☐ Divorced	Gender (check one) ☐ Male ☐ Female	Has this insurance been assigned? ☐ Yes ☐ No

Address	City	State	ZIP Code	Daytime Phone	Home Phone	Date of Birth	Date of Hire	Date of Retirement (if applicable)

Name of Employer/Group Policyholder	Group Policy No	**Unless otherwise indicated below, this Beneficiary Designation/Change form applies to ALL coverages offered under my employer's group plan.** This form applies only to my coverage(s).

2. BENEFICIARY DESIGNATION: I hereby revoke any previous designations of primary beneficiary(ies) and contingent beneficiary(ies), if any, and in the event of my death, designate the following:

A. Primary Beneficiaries

Beneficiary Description (check one)	**First Name**	**MI**	**Last Name**	**Address (include city, state, ZIP)**	**Relationship**	**Date of Birth**	**% Share**
☐ Individual ☐ Other_______________ ☐ Trust ☐ Corporation/Organization							
☐ Individual ☐ Other_______________ ☐ Trust ☐ Corporation/Organization							
☐ Individual ☐ Other_______________ ☐ Trust ☐ Corporation/Organization							
☐ Individual ☐ Other_______________ ☐ Trust ☐ Corporation/Organization							
						TOTAL: (must equal 100)	

B. Contingent Beneficiaries

Beneficiary Description (check one)	**First Name**	**MI**	**Last Name**	**Address (include city, state, ZIP)**	**Relationship**	**Date of Birth**	**% Share**
☐ Individual ☐ Other_______________ ☐ Trust ☐ Corporation/Organization							
☐ Individual ☐ Other_______________ ☐ Trust ☐ Corporation/Organization							
☐ Individual ☐ Other_______________ ☐ Trust ☐ Corporation/Organization							
☐ Individual ☐ Other_______________ ☐ Trust ☐ Corporation/Organization							
						TOTAL: (must equal 100)	

3. TRUST DESIGNATION - COMPLETE IF A TRUST HAS BEEN NAMED AS A BENEFICIARY IN SECTION 2

Trustee's Name (First, MI, Last)	**Address (include city, state, ZIP)**

And successor(s) in trust, as Trustee(s) under ______________________________ **dated** __________________ **as amended and executed by me and said Trustee.**

Title of Agreement *Date of Agreement*

4. AUTHORIZATION/SIGNATURE I authorize my plan administrator to record and consider the individuals/institutions that I have named on this form as beneficiaries for benefits under the applicable employee benefit plans. If designating a trust as a beneficiary, I understand Prudential assumes no obligation as to the validity or sufficiency of any executed Trust Agreement and does not pass on its legality. In making payment to any Trustee(s), Prudential has the right to assume that the Trustee(s) is acting in a fiduciary capacity until notice to the contrary is received by Prudential at its Group Life Claim office. I agree that if Prudential makes any payment(s) to the Trustee(s) before notice is received, Prudential will not make payment(s) again.

Employee's Signature **X** ____ Date __________________

The employee must sign and date this form. The signature date must be the date the employee actually signed the form.

Group Life coverage is issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. Please refer to the Booklet-Certificate, which is made a part of the Group Contract, for all plan details, including any exclusions, limitations and restrictions which may apply. Prudential and the Rock logo are registered service marks of The Prudential Insurance Company of America and its affiliates.

GL.2001.169 Ed. 12/2011