CHCA Community HealthCare Alliance

A DIVISION OF ABC

12137 Rhea Drive, Suite A, Plainfield, IL 60585 phone (815) 609-6715 fax (815) 609-9645 www.abcins.com

UNICARE HMO BENEFITS

Effective May 1, 2008 through April 30, 2009

BENEFITS	Unicare Pays	You Pay
DEDUCTIBLE & LIFETIME MAXIMUM	Services and supplies must be provided or authorized by your Primary Care Physician	
ANNUAL DEDUCTIBLE	NOT APPLICABLE	
OOP COPAYMENT MAXIMUM (2X FAMILY)	$1,500	
INDIVIDUAL LIFETIME MAXIMUM	UNLIMITED	
PREVENTATIVE CARE		
ROUTINE PHYSICAL EXAMS	100% AFTER COPAYMENT	$25 COPAYMENT PER VISIT
DIAGNOSTIC X-RAY & LAB TESTS		
IMMUNIZATIONS		
ALLERGY TREATMENT & TESTING		
WELLNESS CARE		
PHYSICIAN SERVICES		
OFFICE VISITS TO HEALTHCARE PROVIDER (PCP & Specialty)	100% AFTER COPAYMENT	PCP - $25 COPAYMENT PER VISIT Specialty - $50 COPAYMENT PER VISIT
MATERNITY - PRENATAL	100%	$25 COPAYMENT (initial prenatal visit only)
DELIVERY & POST PARTUM CARE	100%	$0
HOSPITAL SERVICES		
INPATIENT (semi-private room)	100% AFTER COPAYMENT	$400 COPAYMENT
OUTPATIENT SURGERY	100%	$0
EMERGENCY CARE	100% AFTER COPAYMENT	$75 COPAYMENT (waived if admitted)
OTHER SERVICES		
SKILLED NURSING FACILITY	100% Up to 60 days per condition	$0 up to 60 days per condition 100% AFTER 60 visits per condition
HOME HEALTHCARE	100% Up to 60 visits per condition	$0 up to 60 visits per condition 100% AFTER 60 visits per condition
DURABLE MEDICAL EQUIPMENT (Rental or purchase per plan decision)	100%	0%
EYE EXAMS (Screening for and treatment of eye disease and eye surgery every 24 months.)	100% AFTER COPAYMENT	$35 COPAYMENT PER VISIT
REHABILITATIVE SERVICES		
OUPATIENT REHABILITATION: Physical, Occupational & Speech Therapy	100% after copayment, up to 60 visits per calendar year	$25 copayment per visit up to 60 visits per calendar year, then 100%.
MENTAL HEALTH	INPATIENT: 100% up to 30 days per calendar year. OUTPATIENT: 100% after copayment, up to 20 visits per calendar year	INPATIENT: $0 up to 30 days per calendar year, then 100%. OUTPATIENT: $20 copayment per visit up to 20 visits per calendar year, then 100%.
SUBSTANCE ABUSE	INPATIENT: 100% up to 30 days per calendar year. OUTPATIENT: 100% after copayment, up to 20 visits per calendar year	INPATIENT: $0 up to 30 days per calendar year, then 100% OUTPATIENT: $20 copayment per visit up to 20 visits per calendar year, then 100%.
PRESCRIPTION DRUG BENEFIT		
PRESCRIPTIONS	100% AFTER COPAYMENT	COPAYMENTS: $15 level 1 / $30 level 2 / $60 level 3
PROCEDURES AND DEFINITIONS		
Lifetime Maximum: Psychiatric, Alcohol & Drug Related Services	The lifetime maximum benefit for psychiatric, alcohol and drug related services is $50,000 combined in- and out- patient service.	
Coordination of Benefits	All benefits are subject to coordination of benefits with other plans. The total benefits payable under this plan for a covered person when combined with other group health plan benefits will not be more than 100% of allowable charges.	
Copay	The amount a patient is required to pay to a network provider at the time of service.	
Medical Emergency	Medical conditions of sufficient severity such that a layperson could reasonably expect the absence of immediate medical attention to result in serious jeopardy of the person's health, serious impairment to bodily functions, or serious dysfunction of any organ or part.	

(Continued on Page 2)

Plan includes $15,000 life insurance for primary insured only (doubled for AD&D).

For a more complete list of the Unicare HMO benefits, see www.abcins.com.

CHCA UNICARE HMO BENEFITS
Effective May 1, 2008 through April 30, 2009

Services and supplies not covered by plan

- Services and supplies that are not authorized by the primary care physician except treatment for medical emergencies in the first 48 hours of onset.
- Fees over usual and prevailing charge for non-participating providers in connection with a medical emergency.
- Dental and related services. Treatment for temporo-mandibular joint syndrome.
- Services that are not medically necessary. Services that are experimental, investigational and/or educational.
- Routine exams and immunizations solely for the purpose of insurance, licensure, employment or travel.
- Work related illnesses or injuries. Services and supplies relating to military service connected disabilities.
- Services and supplies furnished by the U.S. government and at public facilities.
- Corrective appliances and artificial aids including hearing aids. Hearing aid exams to determine the need for hearing aids or to adjust them.
- Treatment of foot conditions except for a open cutting operation, removal of nail root and treatment in connection with metabolic or peripheral vascular disease or of a neurological condition.
- Services and supplies in connection with a medical emergency after 48 hours unless proper notice and primary care physician authorized.
- Planned home deliveries and delivery outside the service area against medical advice.
- Eye surgery to correct myopia, hyperopia or astigmatism.
- Cosmetic surgery and supplies.
- Sex changes and reversal of previous voluntary sterilization.
- Charges made by the employer or close relative.
- Over the counter drugs and items.
- Services and supplies for weight loss.
- Blood or blood plasma including the collection and storage.
- Procedures specific to sex preselection and/or determination.
- Collection and storage of sperm, oocytes, or embryos for later use.
- Transportation except for emergency transportation.
- Services and supplies required by court decree.
- Non-medical costs. Non-eligible drugs.
- Visits, days and maximum amounts over the plan limits.
- Custodial care. Personal comfort and convenience items and services.

CHCA Unicare HMO Rates

Good through April 2009

Employee only	$ 639.74
Employee & Spouse	$ 1,462.45
Employee & children	$ 1,273.42
Family	$ 2,242.40

How to find a participating physician on Unicare's website

1. Go to www.unicare.com
2. Click on "Find a Doctor"
3. Select "Visitor Search" and "Continue"
4. Select "Large Group Plans" and "Continue"
5. Under "Select a Plan", click on the arrow for a drop down menu.
   Scroll down and select "Unicare HMO Performance (Metro Chicago)", then "continue"
6. Under "Select a Provider Type", click on the arrow for a drop-down menu to make your choice(s), then "continue".
7. Select either "Search by Location" or "Search by Name", provide search criteria, then choose "Find Providers Now" or "Further Refine Search" for "Additional Search Criteria"
8. If you get the response "No provider met the preferences you selected", you must broaden your search.

OR call Unicare Member Services at (312) 234-8855 to find a network physician or hospital.

Shaded areas are for Office use only (Please type or print)

UNICARE HMO

SUBSCRIBER APPLICATION

New Hire ___ COBRA ___

To Be Completed By Employer:

Date Employed_____ Effective Date_____ Employer Group Name_____ Group Number _____

To be completed by UNICARE HMO **Group #** _____ **Effective Date** _____

To Be Completed By Subscriber: **It is important to select a Primary Care Physician (PCP) for each family member.**

UNICARE Health Plans of the Midwest, Inc., an Illinois corporation, is separately incorporated and capitalized companies owned by UNICARE Health Plans, an Illinois general partnership. Both are separately formed and capitalized subsidiaries of WellPoint Health Networks Inc., a Delaware corporation, and are part of the WellPoint Health Networks Inc. family of companies. UNICARE HMO is a health care benefits product of UNICARE Health Plans of the Midwest, Inc.

Last Name First Name Initial

Home Address Apt. Number

City State Zip Code Home Phone Business Phone

Member Social Security Date of Birth

Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Widowed

Gender: ( ) Male ( ) Female

Primary Care Physician Medical Office or Group

Hospital Current Patient Yes _____ No _____

If applying for family coverage, list spouse and eligible dependents below:

			Sex	Date of Birth			Relationship to Subscriber
(Spouse) Last Name (02)	First Name		M___ F___	MO	DAY	YR	
Select a PCP	Medical Office	Hospital	Current Patient Yes ___ No ___ SS#				
(Eligible Children) Last Name (03)	First Name		M___ F___	MO	DAY	YR	
Select a PCP	Medical Office	Hospital	Current Patient Yes ___ No ___ SS#				
Last Name (04)	First Name		M___ F___	MO	DAY	YR	
Select a PCP	Medical Office	Hospital	Current Patient Yes ___ No ___ SS#				
Last Name (05)	First Name		M___ F___	MO	DAY	YR	
Select a PCP	Medical Office	Hospital	Current Patient Yes ___ No ___ SS#				
Last Name (06)	First Name		M___ F___	MO	DAY	YR	
Select a PCP	Medical Office	Hospital	Current Patient Yes ___ No ___ SS#				

Have you previously been a member of UNICARE HMO formerly known as Rush Prudential HMO?_____ Yes _____ No

If yes, please indicate name of group or group number _____

COORDINATION OF BENEFITS INFORMATION

Do you (or any of the above) have other Health Insurance Coverage? _____

If yes, please provide the name of the insurance company _____

Effective Date _____ **Type of coverage Single** _____ **Family** _____

Name of Insured: _____ **Policy #** _____

Name of Group: _____ **Phone #** _____

I elect coverage, as indicated above, and authorize my employer to deduct required contributions (if any) from my earnings, I hereby authorize all hospitals, physicians, medical service providers, pharmacists, employers, and all other agencies or organizations (including insurers, service organizations and other health care service, benefit and/or pre-paid health plans) to permit UNICARE HMO, its affiliates or their representatives to see, or, to get a copy of all past, present and future medical, prescribed drug, employment and insurance coverage records which pertain to me or any covered member of my family. This information will be used in connection with claims for benefits (and other services provided by UNICARE HMO under the plan). This authorization shall remain valid for the term of this coverage. The person who signs this form may have a copy upon request. I understand that, if a member is injured through the act or omission of another, UNICARE HMO requires reimbursement for the benefits provided in an amount to exceed any damages collected (where permitted by law).

_____ Subscriber Signature

_____ Date

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Applicant's Social Security No.

UNICARE

Individual Enrollment Application - Illinois

UNICARE Health Insurance Company of the Midwest

- *Application must be completed by the applicant in blue or black ink.*

1. Applicant Information *(Please Print)*

Primary Applicant's Last Name	First Name	M.I.
Home Address *(Residence address required; P.O. Box not acceptable)*		
City	State	ZIP Code

Reason for Application *(Check one)*

☐ New Enrollment(s)

☐ Add dependent(s) to I.D. No:_____

Mailing Address *(If different than above)* (P.O. Box or Personal Mail Box No.)			Home Phone No. ( )	E-mail Address *(Optional)*
City	State	ZIP Code	Daytime Phone No. ( )	Fax No. ( )
In care of:			Marital Status ☐ Single ☐ Married	Spouse's Social Security No. *(Required)*
			Maiden Name of Applicant / Spouse *(If applicable)*	

Has any person listed on this application resided outside the U.S. for the past six (6) consecutive months? ☐ Yes ☐ No
If yes, please provide name and explain:

2. Employer Information

Name	Phone No.

3. Applicants for Coverage

Please list *all* applicants applying for coverage. *(List children youngest to oldest)*
If a family member's last name is different than yours, please attach explanation to application.

Relation	Last Name	First Name	M.I.	MUST BE ACCURATE Height	MUST BE ACCURATE Weight	Date of Birth	Social Security No.	✓ Full Time Student
☐ Male ☐ Female	Yourself							
☐ Husband ☐ Wife	Spouse							
☐ Son ☐ Daughter								
☐ Son ☐ Daughter								
☐ Son ☐ Daughter								
☐ Son ☐ Daughter								
☐ Son ☐ Daughter								

Applicant's Social Security No.

4. Other Coverage - *Please answer **all** of the following questions.*

A. Do you currently have, or has anyone to be insured had coverage in the last 18 months? ☐ Yes ☐ No

If Yes, please provide the following information.

Name of insured	Insurance carrier(s)	Effective date	End date

Do you agree to discontinue your current coverage if this application is accepted? ☐ Yes ☐ No

If No, please explain:

B. Has anyone on this application been insured by UNICARE in the last 5 years? ☐ Yes ☐ No

If Yes, please provide the following information.

Name of insured	Plan/I.D. No.	Group No.	
Name of Plan	City	State	Date cancelled

C. If any applicant has/had UNICARE group coverage, please complete the following:

I certify that my UNICARE group coverage will end/ended on (date):

☐ **I do not wish to enroll in any available Conversion Agreement.** I understand that with the coverage for which I am applying with this application there may be a lapse in coverage. If accepted with or without lapse in coverage, each person will be subject to new waiting periods and deductibles.

D. Has anyone identified on this application ever been declined, postponed, had a waiver applied, or charged an extra premium for life, disability, or health insurance, or had such insurance rescinded? ☐ Yes ☐ No

If Yes, please provide the following information.

1. Name of applicant	Name of Insurance Company	Explain
2. Name of applicant	Name of Insurance Company	Explain
3. Name of applicant	Name of Insurance Company	Explain

E. Are any persons applying for coverage on this application eligible for Medicare benefits? ☐ Yes ☐ No

If Yes, please list all eligible person(s). Note: Any applicant eligible for Medicare Part A or B is **not** eligible for this coverage.

Eligible person(s)

F. Has anyone applying for coverage on this application filed a claim for disability or Workers' Compensation within the past 18 months? ☐ Yes ☐ No

If Yes, please provide the following information.

Name of applicant	Effective date	End date

5. Health Questions

	1. Family member	Amount per day	2. Family member	Amount per day
1. Has any applicant ever smoked or used any tobacco products, such as: cigarettes, cigars, pipe, snuff, or chewing tobacco? ☐ Yes ☐ No	Type of product	Date Discontinued	Type of product	Date Discontinued
2. Has any applicant used illegal or controlled drugs, or substances such as marijuana, cocaine, methamphetamines, in the last 10 years, or been diagnosed as chemically or alcohol dependent? ☐ Yes ☐ No	1. Family member		2. Family member	
	Type of product	Date Discontinued	Type of product	Date Discontinued
3. Has any applicant ever used any illegal or controlled I.V. drugs? ☐ Yes ☐ No	1. Family member		2. Family member	
	Type of product	Date Discontinued	Type of product	Date Discontinued
4. Has any applicant consumed any alcoholic beverages in the last 6 months? ☐ Yes ☐ No *Amount: A drink is 12 oz. of beer, 6 oz. of wine, or 1 oz. of liquor.*	1. Family member		2. Family member	
	Amount _____ per ☐ day ☐ week ☐ month		Amount _____ per ☐ day ☐ week ☐ month	
	Type of Product		Type of Product	
5. Has any applicant been advised to reduce alcohol intake within the past 10 years? ☐ Yes ☐ No	1. Family member	Date Discontinued	2. Family member	Date Discontinued

Applicant's Social Security No. | | | | | | | | | |

6. Health History – Include information on *all* family members you wish to enroll.

6A. Health History Questionnaire – *ALL* QUESTIONS MUST BE ANSWERED OR THE APPLICATION MAY BE RETURNED AND/OR REJECTED. If you answer "Yes" to any question in Section 6A, you must give complete details in Section 6B.

Has any person listed on this application had a clear, distinct symptom that would cause an ordinarily prudent person to seek advice or treatment, or had treatment recommended, received treatment, or been hospitalized for any of the following conditions listed in questions 1 through 24 **within the last 10 years:**

1. Frequent and/or severe headaches, migraines, seizures, epilepsy, multiple sclerosis, or any other neurological or central nervous system disorder(s) ☐ Yes ☐ No
2. Dizziness, weakness, fainting, numbness/tingling, head injury, paralysis, stroke, confusion, memory loss, loss of consciousness, narcolepsy, or any similar symptoms ☐ Yes ☐ No
3. Chest pain, high or low blood pressure, heart disease, heart attack, heart murmur, palpitations, pacemaker, or any other heart disorder or condition ☐ Yes ☐ No
4. Poor circulation, blood clot, varicose veins, enlarged lymph nodes, blood/bleeding disorder, anemia, rheumatic fever, or any other circulatory condition ☐ Yes ☐ No
5. Allergies, difficulty breathing, shortness of breath, asthma, chronic cough, spitting/coughing up blood, respiratory/lung infections, sinusitis, bronchitis, pneumonia, pneumocystis carinii pneumonia (PCP), tuberculosis, emphysema, or any other respiratory disorder or condition ☐ Yes ☐ No
6. Diseases or problems of the nose, nosebleeds, polyps, deviated nasal septum, excessive snoring, or use of a sleep monitoring device ☐ Yes ☐ No
7. Diseases or problems of the mouth/gums, throat/swallowing, tonsils, adenoids, jaw/chewing problems or TMJ ☐ Yes ☐ No
8. Gastric reflux, ulcers, hernia, intestinal problems, diverticulitis, colitis, diarrhea, rectal problems/bleeding, polyps, hemorrhoids, or any other digestive disorder or condition ☐ Yes ☐ No
9. Gallbladder, spleen, pancreatitis, liver disease, jaundice, unexplained weight loss/gain, or hepatitis (indicate type:_____) ☐ Yes ☐ No
10. Kidney/bladder/urinary tract infections, stones, incontinence, blood in urine or any other disease or disorders of the kidneys or urinary system ☐ Yes ☐ No
11. Bone, joint and/or muscle pain, injury or disorder of joint/tendon/ligament/disc, weakness of back/spine/neck/joint, fracture, sprain/strain, fibromyalgia, arthritis, gout, polio, or any other musculoskeletal disorder ☐ Yes ☐ No
12. Physical handicap, joint replacement, hardware (pins, plates, screws, etc.), amputation, or prosthesis ☐ Yes ☐ No
13. Diabetes, thyroid, pituitary, adrenal, or any other endocrine disorders ☐ Yes ☐ No
14. Immune disorders, lupus, scleroderma, mononucleosis, chronic fatigue syndrome ☐ Yes ☐ No
15. Is any applicant a candidate for, or a recipient of an organ or bone marrow transplant? ☐ Yes ☐ No
16. Skin infections, cancer, melanoma, lesion, psoriasis, keratosis, warts, ulcers, birthmarks, severe burns, acne, fungal infections, Kaposi's sarcoma, eczema, dermatitis, hyperhidrosis, herpes, scars/keloids, cosmetic or reconstructive surgery, or any other skin conditions ☐ Yes ☐ No
17. Sexually transmitted disease, such as herpes, genital warts, etc. ☐ Yes ☐ No
18. Male applicant(s)
    a) Prostate, undescended testes, infertility, low sperm count, impotence, sexual dysfunction, or implant ☐ Yes ☐ No
    b) Is any male listed on this application expecting a child or in the process of adoption or surrogate pregnancy with anyone, whether or not the mother is listed on this application? ☐ Yes ☐ No
19. Female applicant(s)
    a) Breast disorder/cyst, lump, fibroid tumors, silicone injections, or implants ☐ Yes ☐ No
    b) Pelvic pain, menstruation disorders, abnormal pelvic exam/PAP smear, endometriosis, uterine fibroids, ovarian cysts, infertility or miscarriages ☐ Yes ☐ No
    c) Date and result of last pelvic exam/Pap smear for each female over 16:
    Name:_____ Mo/Day/Yr:_____ ☐ Normal ☐ Abnormal
    Name:_____ Mo/Day/Yr:_____ ☐ Normal ☐ Abnormal
    Name:_____ Mo/Day/Yr:_____ ☐ Normal ☐ Abnormal
    d) Is the applicant, spouse or any female dependent, whether or not listed on the application, currently pregnant, or in the process of adoption or surrogate pregnancy? ☐ Yes ☐ No
20. Diseases or problems of the eyes or sight, crossed eyes, glaucoma, cataracts, detached retina or blurred vision ☐ Yes ☐ No
21. Diseases or problems of the ears or hearing, implant, or hearing aid ☐ Yes ☐ No
22. Eating disorder, depression, anxiety, counseling, member of a support group, bi-polar, chemical imbalance, attention deficit disorder, schizophrenia, obsessive-compulsive, panic disorder, etc. ☐ Yes ☐ No
23. Mental or physical impairment or deformity, congenital abnormalities or birth defects Specify:_____ ☐ Yes ☐ No
24. Has any applicant consulted a provider for any condition or symptom(s) for which a diagnosis has not been established? ☐ Yes ☐ No

Has any person listed on this application **ever**:

25. Had cancer, tumor/growth, leukemia, or cyst? ☐ Yes ☐ No
26. Had an abnormal physical exam, laboratory results, x-rays, EKG, MRI, CT scan or been advised to undergo further testing surgery, or treatment? ☐ Yes ☐ No
27. Seen, been a patient in a hospital, clinic, or other medical facility, received treatment from or consulted any doctor, or other person providing health care services for any other condition or symptom(s) (excluding childbirth) not listed on this application? ☐ Yes ☐ No
28. Been diagnosed or received treatment by a physician or health care professional for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or tested positive for HIV (Human Immunodeficiency Virus)? ☐ Yes ☐ No

IMPORTANT: ***Applicant's medical conditions, which occur after the signature date and before the approval date that come to UNICARE's attention, may be considered in the final underwriting decision.***

6B. Professional Services

Give COMPLETE details of any "Yes" answers to the questions in 6A. (Use additional sheets if necessary.)

Applicant's Social Security No.

Question # Name of Family Member	Date of Onset	Name of Physician/Hospital/Other Facility			Date of Visit
Name of Condition/Illness	Date Ended	Address			Phone No.
Treatment (X-ray, lab, surgery, etc.)	Degree of Recovery	City	State	ZIP	Fax No.
Results ☐ Normal ☐ Abnormal ☐ Still under treatment		Medications			Frequency
If abnormal, please explain:		Dosage	Date Prescribed		Date Discontinued

Question # Name of Family Member	Date of Onset	Name of Physician/Hospital/Other Facility			Date of Visit
Name of Condition/Illness	Date Ended	Address			Phone No.
Treatment (X-ray, lab, surgery, etc.)	Degree of Recovery	City	State	ZIP	Fax No.
Results ☐ Normal ☐ Abnormal ☐ Still under treatment		Medications			Frequency
If abnormal, please explain:		Dosage	Date Prescribed		Date Discontinued

Question # Name of Family Member	Date of Onset	Name of Physician/Hospital/Other Facility			Date of Visit
Name of Condition/Illness	Date Ended	Address			Phone No.
Treatment (X-ray, lab, surgery, etc.)	Degree of Recovery	City	State	ZIP	Fax No.
Results ☐ Normal ☐ Abnormal ☐ Still under treatment		Medications			Frequency
If abnormal, please explain:		Dosage	Date Prescribed		Date Discontinued

Question # Name of Family Member	Date of Onset	Name of Physician/Hospital/Other Facility			Date of Visit
Name of Condition/Illness	Date Ended	Address			Phone No.
Treatment (X-ray, lab, surgery, etc.)	Degree of Recovery	City	State	ZIP	Fax No.
Results ☐ Normal ☐ Abnormal ☐ Still under treatment		Medications			Frequency
If abnormal, please explain:		Dosage	Date Prescribed		Date Discontinued

6C. Prescription Medications –
List all medications not noted above taken within the last 12 months by any family member listed on this application.

Family Member	Medication and Dosage	Illness for which Medication is Prescribed	Date Prescribed	Date Discontinued	Name, Phone No. & FAX No. of Physician or Hospital Address/City/State/ZIP Code

To provide further information, please use additional sheets if necessary. List the page number, section name, and question number you are explaining. Also, please identify the applicable family member. All additional sheets must be signed by the applicant. ☐ **No. of sheets attached**

UNICARE.

Life Claims Service Center
P.O. Box 724767
Atlanta, GA 31139-1767

EMPLOYEE – Send this info to

POLICYHOLDER – Complete section "1" before giving to employee.

SECTION I **Required for Identification**

Employer (or Policyholder) Name and Address	Group Number
Community HealthCare Alliance 12137 Rhea Drive, Unit A Plainfield, IL 60544 Phone 815-609-6715 Fax 815-609-9645	1603NX

SECTION II – ADD / CHANGE BENEFICIARY

I, _____ , hereby revoke all previous
Name of Insured Person
nominations of beneficiaries under the Insurance on my life, including insurance for accidental death if any provided under Group Policy(ies) # 1603NX .

I nominate the following beneficiary(ies) with respect to all insurance now or hereafter provided under said policy(ies), in still reserving to myself the privilege of other and further changes, subject to the provisions of the policy or policies.

Full Name	Address	Relationship	Age	Social Security No.

If more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiaries (or beneficiary) as survive me, unless otherwise provided herein. If no designated beneficiary survives me, settlement will be made as provided for in the policy(ies).

This change of beneficiary shall take effect as provided for in the policy(ies), and when received as so provided, the change shall be operative as of the date of this instrument whether or not I am alive at the time of such receipt, but without prejudice to the Company on account of any payment made by it before such receipt. The Company shall be bound by any trust deed, and shall not be liable for the application of monies by a trustee beneficiary.

SECTION III – CHANGE OR CORRECTION OF INSURED'S NAME OR BENEFICIARY'S NAME

It is hereby requested that the name of the ☐ INSURED ☐ BENEFICIARY appearing on the Insurance records

_____ as _____

be changed to _____ because of _____

I HEREBY AUTHORIZE the changes in Section II and/or III.

Date _____ _____
Signature of Insured Person

ACKNOWLEDGMENT The authorized change(s) set forth in the foregoing instrument are hereby acknowledged.

Dated at _____ _____
Authorized By

On _____ _____
Title