

# Beneficiary Designation Form



# EQUITABLE

**Address:** Equitable's Employee Benefits Group  
8501 IBM Dr., Ste. 150-B  
Charlotte NC 28262

Equitable Financial Life Insurance Company  
Equitable Financial Life Insurance Company of America\*  
For Assistance Call (866) 274-9887

## Important Information about Beneficiary Designations

Use this form to designate or make changes to the beneficiary(ies) of your Group Insurance death proceeds. The information on this form will replace any prior beneficiary designation. You may name anyone or any entity as your beneficiary and you may change your beneficiary at any time by completing a new Group Insurance Beneficiary Designation/Change form. Common designations include individuals, estates, corporation/organizations and trusts. Payment will be made to the named beneficiary. If there is no name beneficiary predeceased the insured, settlement will be made in accordance with the terms of your Group Contract.

## Definitions

**You may find the following definitions helpful in completing this form:**

**Primary Beneficiary(ies)** – the person(s) or entity you choose to receive your life insurance proceeds. Payment will be made in equal shares unless otherwise specified. In the event that a designated primary beneficiary predeceases the insured, the proceeds will be paid to the remaining primary beneficiaries in equal shares or all to the sole remaining primary beneficiary.

**Contingent Beneficiary(ies)** – the person(s) or entity you choose to receive your life insurance proceeds if the primary beneficiary(ies) die (or the entity dissolves) before you die. Payment will be made in equal shares unless otherwise specified. In the event that a designated contingent beneficiary predeceases the insured, the proceeds will be paid to the remaining contingent beneficiaries in equal shares or all to the sole remaining contingent beneficiary.

## INSTRUCTIONS FOR DESIGNATING A PRIMARY OR CONTINGENT BENEFICIARY

### 1. EMPLOYEE INFORMATION

- All information in this section is required.
- Unless otherwise indicated in Section 1, the information supplied on the form will apply to ALL coverages offered under the employer's group plan.
- Unless otherwise indicated in Section 2, the information supplied on this form will apply to all the Group Life and Group Accident coverage(s) issued by Equitable Financial or Equitable America.

### 2. BENEFICIARY DESIGNATION

- You may name more than one primary and more than one contingent beneficiary. This form allows you to name up to four primary and four contingent beneficiaries. If you need additional space, please attach a separate sheet of paper.
- Please indicate the percentage share designated to each primary beneficiary. The total for all primary beneficiaries must equal 100%. If no percentages are specified, the proceeds will be split evenly among those named. Payment will be made to the named beneficiary. If there is no named beneficiary, or the named beneficiary predeceased the insured, settlement will be made in accordance with the terms of your Group Contract. If designating percentages for contingent beneficiaries, the percentage for all contingent beneficiaries must also equal 100%.
- You can name an individual, corporation/organization, trust, or an estate as a beneficiary. The following examples may be helpful in designating beneficiaries.

#### Individual: "Mary A. Doe"

- Each name should be listed as first name, middle name, last name ("Mary A. Doe," not "Mrs. M. Doe")
- Include the address, telephone number, social security number, relationship and Date of Birth for each individual listed.
- Indicate the percentage to be assigned to each individual.

#### Estate: "Estate of the Insured"

- Select "Other" as the Beneficiary Description and write "Estate" in the blank space provided.
- Indicate the percentage to be assigned to the Estate of the Insured.

#### Corporation/Organization: "ABC Charitable Organization"

- Select "Corporation/Organization" as the Beneficiary Description.
- Write the legal name of the corporation or organization in the space for the Beneficiary's First Name.
- Include the address, city and state, telephone number and tax ID number of operation for each organization or corporation listed.
- Indicate the percentage to be assigned to the corporation or organization.

#### Trust: "The John Doe Trust. A Trust with a trust agreement dated 1/1/99 whose Trustee is Jane Smith."

- Select "Trust" as the Beneficiary Description.
- Indicate the percentage to be assigned to the trust.
- Complete Section 3, Trust Designation.

### 3. TRUST DESIGNATION

- Complete this section if you have named a trust as a primary beneficiary in Section 2. Fill in the name and address for each trustee.
- Fill in the title and date of the Trust Agreement in the space provided.

### 4. AUTHORIZATION/SIGNATURE

- The employee must read, sign and date the authorization.
- Submit the completed form to your Benefits Administrator or Human Resources (as directed by your employer) and keep a copy for your records.



Policy Number

Equitable Financial Life Insurance Company  
Equitable Financial Life Insurance Company of America\*  
For Assistance Call (866) 274-9887

**Group Insurance Beneficiary Designation/Change**

Date: \_\_\_\_\_

**1. EMPLOYEE INFORMATION (please print)**

|           |            |       |                                 |   |   |  |                 |                                       |
|-----------|------------|-------|---------------------------------|---|---|--|-----------------|---------------------------------------|
| Last Name | First Name | MI    | Employee ID#<br>(if applicable) | Marital Status<br>(check one)<br>___ Married ___ Widow<br>___ Single ___ Divorced | Gender<br>(check one)<br>___ Male<br>___ Female | Has this insurance<br>been assigned?<br>___ Yes ___ No |                 |                                       |
| Address   | City       | State | Zip Code                        | Daytime<br>Phone  | Home<br>Phone                                   | Date of<br>Birth                                       | Date of<br>Hire | Date of Retirement<br>(if applicable) |

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 \_\_\_ Basic Life \_\_\_ Basic AD&D \_\_\_ Supplemental/Voluntary Life \_\_\_ Supplemental/Voluntary Life AD&D \_\_\_ Dependent Life \_\_\_ Dependent Life AD&D \_\_\_ Group Accident

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

**A. Primary Beneficiaries**

| Beneficiary Description  | First Name | MI | Last Name | Address<br>(include city, state, Zip) | Relationship | Date of Birth | SSN/Tax ID Number | Phone | % Share |
|--|------------|----|-----------|---------------------------------------|--------------|---------------|-------------------|-------|---------|
| ___ Individual<br>___ Other<br>___ Trust<br>___ Corporation/<br>___ Organization |            |    |           |                                       |              |               |                   |       |         |
| ___ Individual<br>___ Other<br>___ Trust<br>___ Corporation/<br>___ Organization |            |    |           |                                       |              |               |                   |       |         |
| ___ Individual<br>___ Other<br>___ Trust<br>___ Corporation/<br>___ Organization |            |    |           |                                       |              |               |                   |       |         |
| ___ Individual<br>___ Other<br>___ Trust<br>___ Corporation/<br>___ Organization |            |    |           |                                       |              |               |                   |       |         |
| <b>Total: (Must equal 100%)</b>  |            |    |           |                                       |              |               |                   |       |         |

Policy Number



**EQUITABLE**

Equitable Financial Life Insurance Company  
 Equitable Financial Life Insurance Company of America\*  
 For Assistance Call (866) 274-9887

**Group Insurance Beneficiary Designation/Change**

Date: \_\_\_\_\_

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

**B. Contingent Beneficiaries**

| Beneficiary Description  | First Name | MI | Last Name | Address (include city, state, Zip) | Relationship | Date of Birth | SSN/Tax ID Number | Phone | % Share                         |
|--|------------|----|-----------|------------------------------------|--------------|---------------|-------------------|-------|---------------------------------|
| ___ Individual<br>___ Other<br>___ Trust<br>___ Corporation/<br>___ Organization |            |    |           |                                    |              |               |                   |       |                                 |
| ___ Individual<br>___ Other<br>___ Trust<br>___ Corporation/<br>___ Organization |            |    |           |                                    |              |               |                   |       |                                 |
| ___ Individual<br>___ Other<br>___ Trust<br>___ Corporation/<br>___ Organization |            |    |           |                                    |              |               |                   |       |                                 |
| ___ Individual<br>___ Other<br>___ Trust<br>___ Corporation/<br>___ Organization |            |    |           |                                    |              |               |                   |       |                                 |
|  |            |    |           |                                    |              |               |                   |       | <b>Total: (Must equal 100%)</b> |

**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.

Policy Number



**EQUITABLE**

Equitable Financial Life Insurance Company  
Equitable Financial Life Insurance Company of America\*  
For Assistance Call (866) 274-9887

**Group Insurance Beneficiary Designation/Change**

---

**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 Equitable 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). Equitable has the right to assume that the Trustee(s) is acting in a fiduciary capacity until notice to the contrary is received by Equitable at its Group Life Claim office. I agree that if Equitable makes any payment(s) to the Trustee(s) before notice is received, Equitable will not make payment(s) again.

**Employee's Signature** \_\_\_\_\_ **Date Signed** \_\_\_\_\_

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