Clear Form

BENEFICIARY DESIGNATION

THE HARTFORD

☐ Initial Beneficiary Designation(s) OR ☐ Change of all prior beneficiary designation(s) *(check only one box),* I hereby revoke any previous beneficiary designation(s), if any, for my accidental death and dismemberment (AD&D) insurance issued to this group or employer and direct that the insurance proceeds payable under the policy be paid as indicated below.

Employee Name	Social Security Number
Employee Address	Telephone Number
Policyholder/Employer **Pennsylvania State University**	Policy/Employer Number **S06238**

NAMING THE AD&D BENEFICIARY

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 contingent beneficiary. When naming your beneficiary(ies) please indicate their full name, address, social security number, 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. If you need assistance, contact your Company representative or your own legal counsel.

Benefits payable for a Dependent's death are payable to You if living, otherwise, We may, at Our option, pay the benefit to Your surviving spouse or to the executors or administrators of Your estate.

PRIMARY BENEFICIARY(IES)

Name: ______________________ Date of Birth ______________

Address: ______________________

Social Security Number: ____________ Relationship: ____________ Benefit Percent: ____________

Name: ______________________ Date of Birth ______________

Address: ______________________

Social Security Number: ____________ Relationship: ____________ Benefit Percent: ____________

CONTINGENT BENEFICIARY(IES)

Name: ______________________ Date of Birth ______________

Address: ______________________

Social Security Number: ____________ Relationship: ____________ Benefit Percent: ____________

Name: ______________________ Date of Birth ______________

Address: ______________________

Social Security Number: ____________ Relationship: ____________ Benefit Percent: ____________

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

Signature of Employee ______________________ **Date** ____________