



P.O. Box 21538 | Eagan, Minnesota 55121-5038
 800.279.4000 WEAtrust.com

Life Insurance Beneficiary Designation

Employee Name (Last, First, Middle Initial)

Social Security Number

Subscriber Number (not applicable for first time enrollment)

Reason for Completing Form (select one)

Initial Designation of Beneficiary

Change of Designation of Beneficiary

Beneficiary Information

Please list your beneficiary's name and relationship to you in the spaces provided. If you list a beneficiary that is not a person (e.g., a charitable organization or trust), please list the relationship as "other." If you designate more than one beneficiary, we will pay the benefits equally to each of your designated beneficiaries. If you want us to pay the benefits in differing percentages, please indicate the percentage for each beneficiary in the space provided. The total for all beneficiaries must equal 100%. If you do not have a named beneficiary, or no beneficiary survives you, payment will be made according to policy provisions.

The beneficiary for insurance on the lives of your dependents will automatically be you, if surviving. Otherwise, the beneficiary will be subject to policy provisions. A beneficiary for employee life or accidental death insurance may be changed upon written request.

Beneficiary Type (select one)	Name (Last, First, Middle Initial)	Relationship to You	
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Date of Birth (MM/DD/YYYY)	Social Security Number	Percentage of Proceeds %

Beneficiary Type (select one)	Name (Last, First, Middle Initial)	Relationship to You	
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Date of Birth (MM/DD/YYYY)	Social Security Number	Percentage of Proceeds %

Beneficiary Type (select one)	Name (Last, First, Middle Initial)	Relationship to You	
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Date of Birth (MM/DD/YYYY)	Social Security Number	Percentage of Proceeds %

Beneficiary Type (select one)	Name (Last, First, Middle Initial)	Relationship to You	
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Date of Birth (MM/DD/YYYY)	Social Security Number	Percentage of Proceeds %

Spousal Consent (complete only if spouse is not designated as primary Beneficiary)

As spouse of the employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse

Date (MM/DD/YYYY)

Signature and Authorization

IMPORTANT: This beneficiary designation revokes all prior beneficiary designations. If you are changing your beneficiary, we will confirm the change in writing. Beneficiary designations are not valid without a signature and date.

Signature

Date (MM/DD/YYYY)