P.O. Box 14319
Lexington, KY 40512

PLEASE TYPE or PRINT CLEARLY. *(The entire form, properly completed, signed and dated by the Insured, must be submitted or the changes cannot be processed.)*

EMPLOYER/PLANHOLDER NAME:	GROUP NUMBER
EMPLOYEE NAME (LAST, FIRST, M.)	SOCIAL SECURITY #
EMPLOYEE HOME ADDRESS (STREET, CITY, STATE, ZIP)	

I AUTHORIZE Guardian or my employer to record and consider the individuals/instructions that I have named on this form as beneficiaries for benefits under the applicable employee benefits plan.
(PLEASE COMPLETE THE APPROPRIATE SECTIONS ONLY.)

BENEFICIARY INFORMATION: *(Complete to designate a beneficiary or change the beneficiary designation); Include full proper name, relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wife, friend, son, daughter.*

Primary: 1) Name	Relationship	%	Social Security #	Date of Birth
Address	Phone#	Email		
2) Name	Relationship	%	Social Security #	Date of Birth
Address	Phone#	Email		
Contingent: 1) Name	Relationship	%	Social Security #	Date of Birth
Address	Phone#	Email		
2) Name	Relationship	%	Social Security #	Date of Birth
Address	Phone#	Email		

If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan.

[redacted] iP shI the Group Plan.