



Underwritten by:  
 Unum Life Insurance Company of America  
 2211 Congress Street, Portland, ME 04122

**Evangelical Free Church of America**  
 Administered by: FCMM Benefits & Retirement  
 901 East 78th Street, Minneapolis, MN 55420  
 Group Long Term Disability Insurance & Term Life/AD&D  
**Enrollment Form**  
 Policy #930391/Div #001

## Form 102: Beneficiary Designation

Please complete the beneficiary information on this form. If you wish to change your beneficiary at any time please complete a new form. The form with the most recent signature date will replace all other elections or directions. Beneficiary designation will affect your LTD Survivor Benefit and Life/AD&D Insurance coverage.

**Employee Social Security Number** \_\_\_\_\_ **Gender**  M  F **Date of Birth (mm/dd/yyyy)** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Employee First Name** \_\_\_\_\_ **M.I. Last Name** \_\_\_\_\_

**Phone Number** \_\_\_\_\_ **Email Address** \_\_\_\_\_

### (I) PRIMARY BENEFICIARIES (REQUIRED)

<u>Name (last name, first, middle initial):</u>	<u>Relation to You:</u>	<u>Benefit %:</u>
(1)		
(2)		

*\*Total of all Primary Beneficiary designations must equal 100%.*

### (II) CONTINGENT BENEFICIARIES (REQUIRED)

If the beneficiary(ies) named above are not living, then pay:

<u>Name (last name, first, middle initial):</u>	<u>Relation to You:</u>	<u>Benefit %:</u>
(1)		
(2)		
(3)		
(4)		

*\*Total of all Contingent Beneficiary designations must equal 100%.*

*I certify all statements I provided are true to the best of my knowledge and belief, and I understand a copy of this form will be made available to me at my request. I have read and understand the "Limitations and Exclusions" included with this enrollment form.*

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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