Designation of Beneficiary Form

Company - Paid Life Insurance



Employer/Group Section (To be completed by the employer/plan administrator. Required fields are marked with an acterick(*).)								
*Employer/Group Name: ET Investments, LLC GTL Policy # GLUG-ARSC Group ID: G000ARSC								
Employee/Member Section (Please print clearly. Required fields are marked with an asterisk(*).)								
*Last Name:			*First Name:			MI	:	
*Social Security Number:			*Ge	ender:		*Marital Status:		
*Street Address:			Email Address:					
*City: *State:		*ZIP Cod	le:	Telephone: (phone: ()			
Beneficiary for Death Benefits (Right to change beneficiary is reserved to the insured.)								
Subject to the terms of the group contract(s), between Mutual of Omaha or a company affiliated with Mutual of Omaha and said employer, I request that the following beneficiary (beneficiaries) be substituted under said contract(s) as my designated beneficiary (beneficiaries), in lieu of any and all beneficiaries previously named by me. If more than one beneficiary is named, the beneficiaries shall share benefits equally unless otherwise stated below. If indicating benefit								
percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Unless otherwise expressly provided, if any beneficiary designated below predeceases me, the share which such beneficiary would have received if such beneficiary had survived me shall be payable equally to the remaining designated beneficiary or beneficiaries. If no designated beneficiary survives me, the beneficiary shall be determined as prescribed in the group contract(s).								
Primary Beneficiary Designation								
Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)		ldress of Benef dress, City, Stat		Benefit Percentage (%)	
					P	ercentage Total:	100%	
Secondary Beneficiary Designation								
Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)		ldress of Benef dress, City, Stat		Benefit Percentage (%)	
					_			
				navonoma karistini saksain	P	ercentage Total:	100%	
Agreement and Signature I understand that this Designation of Beneficiary shall apply to all insurance contracts issued to me by Mutual of Omaha or a company affiliated with Mutual of Omaha, unless I make a separate designation for each coverage, either on or after the date of this designation. I also understand that this Designation of Beneficiary is subject to change as provided in the group contract(s).								
By signing below, I acknowledge that (a) I understand and agree to the terms of this form as noted above; and (b) this Designation of Beneficiary is effective as of the date submitted.								
SIGNATURE OF EMPLOYEE/MEMBER					DATE		_/	