Policy Number 0106696

EQUITABLE

Equitable Financial Life Insurance Company
Equitable Financial Life Insurance Company of America®
For Assistance Call (866) 274-9887

Group Insurance Beneficiary Designation/Change Date: _____

1. EMPLOYEE INFORMATION (please print)

Last Name First Name MI	Employee ID# (if applicable)	Marital Status (check one)	Gender (check one)	Has this insurance been assigned?
		___ Married ___ Widow ___ Single ___ Divorced	___ Male ___ Female	___ Yes ___ No

Address City State Zip Code	Daytime Phone	Home Phone	Date of Birth	Date of Hire	Date of Retirement (if applicable)

Unless otherwise indicated below this Beneficiary Designation/Change form applies to ALL coverages offered under my employer's group plan.

This form applies only to ___ Basic Life X Basic AD&D ___ Supplemental/Voluntary Life ___ Supplemental/Voluntary Life AD&D ___ Dependent Life _____ Dependent Life AD&D

2. BENEFICIARY DESIGNATION: I hereby revoke any previous designations of primary beneficiary(ies) and contingent beneficiary(ies), if any in the event of my death, designate the following:

A. Primary Beneficiaries

Beneficiary Description	First Name	MI	Last Name	Address (include city, state, Zip)	Relationship	Date of Birth	SSN/Tax ID Number	Phone	% Share
___ Individual ___ Other ___ Trust ___ Corporation/ Organization									
___ Individual ___ Other ___ Trust ___ Corporation/ Organization									
___ Individual ___ Other ___ Trust ___ Corporation/ Organization									
___ Individual ___ Other ___ Trust ___ Corporation/ Organization									
							Total: (Must equal 100%)		

Policy Number 0106096

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2. BENEFICIARY DESIGNATION: I hereby revoke any previous designations of primary beneficiary(ies) and contingent beneficiary(ies), if any in the event of my death, designate the following: (continued)

B. Contingent Beneficiaries

Beneficiary Description	First Name	MI	Last Name	Address (include city, state, Zip)	Relationship	Date of Birth	SSN/Tax ID Number	Phone	% Share
___ Individual ___ Other ___ Trust ___ Corporation/ Organization									
___ Individual ___ Other ___ Trust ___ Corporation/ Organization									
___ Individual ___ Other ___ Trust ___ Corporation/ Organization									
___ Individual ___ Other ___ Trust ___ Corporation/ Organization									
							Total: (Must equal 100%)		

3. TRUST DESIGNATION – COMPLETE IF A TRUST HAS BEEN NAMED AS A BENEFICIARY IN SECTION 2

Trustee's Name (First, MI, Last)	Address (include city, state, zip)

And successor(s) in trust, as Trustee(s) under _____ dated _____ as amended and executed by me and said Trustee.

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4. **AUTHORIZATION/SIGNATURE** I authorize my plan administrator to record and consider the individuals/institutions that I have named on this formas beneficiaries for benefits under the applicable employee benefit plans. If designating a trust as a beneficiary, I understand Equitable assumes no obligation as to the validity or sufficiency of any executed Trust Agreement and does not pass on its legality in making payment to any Trustee(s).Equitable has the right to assume that the Trustee(s) is acting in a fiduciary capacity until notice to the contrary is received by Equitable at its Group Life Claimoffice. I agree that if Equitable makes any payment(s) to the Trustee(s) before notice is received, Equitable will not make payment(s) again.

Employee's Signature _____ **Date Signed** _____

The employee must sign and date this form. The signature date must be the date the employee actually signed the form.