Beneficiary Form
Hospital Indemnity Insurance

UnitedHealthcare

Important Note: This Beneficiary Designation cancels any prior beneficiary designation and shall be effective on the date received by the Company			
Policyholder:			
Individual Covered Person	SSN# and DOB:	Phone#	
Street Address (please include apartment # as applicable)	City	State	Zip

THE BENEFICIARY FOR THE POLICY SHALL BE:

Primary Beneficiary				
Name	**Address**	**SSN# and DOB**	**Relationship to the Covered Person**	**% of Death Benefit Payable to Beneficiary (must total 100%)**
In the event, and only in the event, that all Primary Beneficiaries predecease me, then the proceeds shall be payable to the following Contingent Beneficiaries				
Contingent Beneficiary				
Name	**Address**	**SSN# and DOB**	**Relationship to the Covered Person**	**% of Death Benefit Payable to Beneficiary (must total 100%)**

Insured's Signature:_____
Insured's Printed Name: _____
Date: _____

In case I name more than one person in a group of beneficiaries, whether as the Primary beneficiaries or as the Contingent beneficiaries, then unless I otherwise direct in writing above, each designated beneficiary in a group shall share equally in the amount to be paid under the covering policy. In the event any designated beneficiary (ies) in a group predeceases me, then the remaining beneficiary (ies) in that group of beneficiaries shall share equally in the insurance proceeds to be paid under the policy.