



VOLUNTARY BENEFITS DESIGNATION FORM

Instructions:

1. Please complete all personal information. Name, SS#, Certificate #, Full address and Phone Number.
2. Please complete the 'Primary Beneficiary for Employee Coverage' section:
 - a. Beneficiary's Full Name
 - b. % of share
 - c. Relationship
 - d. Date of Birth (MM/DD/YYYY) and/or SS#
 - e. Full address (optional)
 - f. Phone Number (optional)
3. If your certificate is currently assigned, the assignee or trustee must complete all sections of this form.
4. If more than one Primary Beneficiary is being listed, total shares **MUST** equal 100%. Only whole numbers are allowed and must equal 100%. Dollar amounts, fractions and decimals will not be accepted.
5. If more than two Primary Beneficiaries are being listed, please list all required information on a separate sheet in the same format as above. This sheet needs to be signed and dated.
6. If listing Contingent Beneficiaries, please use same format as Primary. Contingent Beneficiaries may **NOT** be the same as a Primary Beneficiary.
7. NO WHITE OUTS, WRITE OVERS, OR CROSS OUTS ALLOWED. Please request a new form if a correction is needed.
8. Please follow the same instructions for the 'Primary Beneficiary for Spouse/Domestic Partner Coverage' and 'Contingent Beneficiary for Spouse/Domestic Partner Coverage' sections when applicable.
9. When naming a Trust as Beneficiary, please include all of the following:
 - a. Name of Trust
 - b. Date Trust was established
 - c. Address for Trust
 - d. Attach a copy of the Trust (optional)
10. When naming a charity or non-profit as Beneficiary, please include all of the following:
 - a. Name of Charity
 - b. Full address
 - c. Phone Number
 - d. Contact Name (local branch)
11. When naming a funeral home as Beneficiary, please include all of the following:
 - a. Name of Funeral home
 - b. Full address
 - c. Phone Number
 - d. Share % you want to go to the Funeral home for expenses



VOLUNTARY BENEFITS DESIGNATION FORM

This form is to designate a beneficiary for life insurance coverage for you and your spouse/domestic partner. Remember: When designating the Primary Beneficiary, be sure that the total shares equal 100%. Your Contingent Beneficiary is the person who will receive the death benefit if your primary beneficiary is no longer living.

Please check
if new address

Owner Name: _____ SS# _____ / _____ / _____
Daytime Phone: (_____) _____ Certificate # _____
Address: _____ City/State/ZIP _____
Owner's Employer (or company insurance obtained from): _____

All previous beneficiary designations are hereby revoked, and the following are designated as beneficiaries under this coverage.

No white outs, write overs, or cross outs allowed in this section.

Primary Beneficiary for Employee Coverage

Full Name: _____

%Share _____ Relationship _____

Address: _____

City/State/ZIP _____

Date of Birth: ____ / ____ / ____ SS# _____

Daytime Phone: (_____) _____

Full Name: _____

%Share _____ Relationship _____

Address: _____

City/State/ZIP _____

Date of Birth: ____ / ____ / ____ SS# _____

Daytime Phone: (_____) _____

Contingent Beneficiary for Employee Coverage (if Primary is not living)

Full Name: _____

%Share _____ Relationship _____

Address: _____

City/State/ZIP _____

Date of Birth: ____ / ____ / ____ SS# _____

Daytime Phone: (_____) _____

Full Name: _____

%Share _____ Relationship _____

Address: _____

City/State/ZIP _____

Date of Birth: ____ / ____ / ____ SS# _____

Daytime Phone: (_____) _____

Primary Beneficiary for Spouse/Domestic Partner Coverage

Full Name: _____

%Share _____ Relationship _____

Address: _____

City/State/ZIP _____

Date of Birth: ____ / ____ / ____ SS# _____

Daytime Phone: (_____) _____

Full Name: _____

%Share _____ Relationship _____

Address: _____

City/State/ZIP _____

Date of Birth: ____ / ____ / ____ SS# _____

Daytime Phone: (_____) _____

Contingent Beneficiary for Spouse/Domestic Partner Coverage (if Primary is not living)

Full Name: _____

%Share _____ Relationship _____

Address: _____

City/State/ZIP _____

Date of Birth: ____ / ____ / ____ SS# _____

Daytime Phone: (_____) _____

Full Name: _____

%Share _____ Relationship _____

Address: _____

City/State/ZIP _____

Date of Birth: ____ / ____ / ____ SS# _____

Daytime Phone: (_____) _____

(The beneficiary for dependent children's coverage is the employee unless otherwise designated)

Community Property Laws - If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, and Wisconsin), and name someone other than your spouse/domestic partner as beneficiary, payment of benefits may be delayed or disputed unless your spouse/domestic partner also signs the beneficiary designation.

Spouse/Domestic Partner's Signature _____ Date _____

I represent the statements and answers given in this request form are true, complete, and correctly recorded to the best of my knowledge and belief. I understand the request for service will not become effective until received at Mercer and approved in accordance with the terms of the coverage.

Owner's Signature _____ Date _____
(Designations are invalid unless Signature and Date are completed)

Please send your signed change form to:

Mercer Voluntary Benefits
PO Box 9122
Des Moines, IA 50306-9122
Fax: (515) 365-1520

FRAUD WARNINGS

For residents of all states and jurisdictions except Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, the District of Columbia, Florida, Idaho, Indiana, Kentucky, Louisiana, Maine, Maryland, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington and West Virginia: **WARNING:** Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he or she is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

ALABAMA RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ALASKA RESIDENTS – A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA RESIDENTS – For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, MASSACHUSETTS, RHODE ISLAND, AND WEST VIRGINIA RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA AND TEXAS RESIDENTS – For your protection, California and Texas law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO RESIDENTS – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE RESIDENTS – Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

IDAHO RESIDENTS – Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA RESIDENTS – A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY RESIDENTS – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE, TENNESSEE, VIRGINIA, WASHINGTON RESIDENTS – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

MARYLAND RESIDENTS – Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA RESIDENTS – A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE RESIDENTS – Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

NEW JERSEY RESIDENTS – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO RESIDENTS – ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NORTH CAROLINA RESIDENTS – Any person who, with the intent to injure, defraud, or deceive an insurer or insurance claimant, knowing that the statement contains false information concerning a fact or matter material to the claim may be guilty of a class H felony.

OHIO RESIDENTS – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA RESIDENTS – WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

OREGON RESIDENTS – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurance company, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

PENNSYLVANIA AND UTAH RESIDENTS – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PUERTO RICO RESIDENTS – Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

VERMONT RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

FLORIDA RESIDENTS – Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NEW YORK RESIDENTS – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

This notice ONLY applies to accident and disability income coverage.