


**INSTRUCTIONS:**

1. Please type or print clearly IN INK.
2. The completed form should be returned to and retained by your Employer.
3. If the presently designated beneficiary is a trustee, attach evidence that the Trust Instrument permits you to make the change requested below.
4. If you are requesting a change to a minor beneficiary, you are reminded that payment of policy proceeds can only be made to a legally appointed and qualified guardian. Have you made these arrangements?
5. Samples of common beneficiary designations are shown at the bottom of this form.

 <p><b>THE LAFAYETTE LIFE INSURANCE COMPANY</b> LAFAYETTE, INDIANA 47903</p>	<p><b>BENEFICIARY DESIGNATION</b> <b>GROUP INSURANCE</b></p>
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PLEASE PRINT

Group Policyholder: UNITED CEREBRAL PALSY of Greater Sacramento Group No: \_\_\_\_\_

Name of insured: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Last
First
Middle Initial

Social Security Number: \_\_\_\_\_

**REQUEST FOR NOMINATION OF BENEFICIARY**

The right is reserved to change the beneficiary hereby designated, without the consent of said beneficiary. If more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiaries (or beneficiary) as survives the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made in accordance with the terms of the above Policy(ies).

**FULL NAME & ADDRESS OF PROPOSED BENEFICIARY**

*Please check Primary (P) or Contingent (C) on each listing below.*

	SOC. SEC. NO.	RELATIONSHIP	DATE OF BIRTH
<input type="checkbox"/> P <input type="checkbox"/> C _____	_____	_____	_____
<input type="checkbox"/> P <input type="checkbox"/> C _____	_____	_____	_____
<input type="checkbox"/> P <input type="checkbox"/> C _____	_____	_____	_____
<input type="checkbox"/> P <input type="checkbox"/> C _____	_____	_____	_____
<input type="checkbox"/> P <input type="checkbox"/> C _____	_____	_____	_____
<input type="checkbox"/> P <input type="checkbox"/> C _____	_____	_____	_____

Dated: \_\_\_\_\_ Yr \_\_\_\_\_ Signature of Insured/Owner: \_\_\_\_\_  
*(Signature is required for a valid Beneficiary Designation)*

**POPULAR BENEFICIARY DESIGNATIONS**

A married woman should be designated by her first name, middle initial and last name.  
 SHOW Jane B. Doe NOT Mrs. John P. Doe.

1. One beneficiary only — Jane B. Doe, wife
2. Two or more beneficiaries, equal amounts — Alice B. Doe, sister  
George M. Doe, brother, and William A. Doe, brother, equally, or to the survivors equally, or to the survivor
3. Two or more beneficiaries, unequal amounts — 50% to James L. Doe, father, 25% each to Alice B. Doe, sister, and William A. Doe, brother,  
The share of any deceased beneficiary to be paid in equal shares to the survivors, or to the survivor
4. Primary and contingent beneficiaries — Jane B. Doe, wife if living; otherwise, the children born of the marriage of the Insured and Jane B. Doe, or legally adopted by them — equally or equally to the survivors.
5. Trustee beneficiary — The Trust Company of Lafayette, Indiana, as trustee under a Trust Instrument dated May 30, 1968.

CHANGE NAME OF  Insured from \_\_\_\_\_  
 Beneficiary to \_\_\_\_\_

**ISSUE OF DUPLICATE CERTIFICATE (POLICY)** because my original certificate (policy) has been lost or mislaid. I declare that such original certificate (policy) has not been pledged as security for any loan and that I do not know where such certificate (policy) is now. If such certificate (policy) is found I will surrender it to the Insurance Company immediately.

DATED \_\_\_\_\_ Yr \_\_\_\_\_ \_\_\_\_\_  
WRITTEN SIGNATURE OF INSURED

\_\_\_\_\_

PRINTED NAME OF INSURED

**The Lafayette Life Insurance Company**

**LTD Enrollment Form**

Employer must complete sections 1,2 and 3	▶ 1. Policy Number	2. Division No.	3. Policyholder's Name United Cerebral Palsy of Greater Sacramento
	4. Employee's Last Name	First	Middle
Employee must complete sections 4, 5, 6 and 7	▶ 5. Social Security Number	6. Employee's Birthdate	7. Sex <input type="checkbox"/> M <input type="checkbox"/> F
Employer must complete sections 8, 9, 11 and 12. Complete section 10 only if working less than your normal work week, less than 30 hours per week or salary is based on an hourly schedule. Section 11 must be exact salary.	▶ 8. Employment Date	9. Employee's Occupation and/or Title	
▶	10. Hours worked weekly	11. Salary \$ <input type="checkbox"/> Weekly <input type="checkbox"/> Annually <input type="checkbox"/> Monthly	12. Insurance effective date
This is to authorize applicable deductions and to verify form accuracy	▶	13. I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. This signature is also to verify the accuracy of the information on this form.	
	▶	Signature	Date

**Employer:** Retain this card in your files. One copy should be sent to the insurer. Be sure to issue the Certificate of Coverage to your employees

*For Employer's Use:*

Date of Salary Change	New Salary Amount	Date of Salary Change	New Salary Amount

*Employee's Last Name* *First* *Middle Initial*

**Declination of Long Term Disability Income Insurance**

This coverage can be declined only if you pay part of or all of the premiums.

I have been offered this LTD insurance coverage and decline to purchase it at this time.

I understand that in the event I desire such insurance at a later date, I will be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse my request.

Signature

Date

Witness' Signature

**Employer:** Declinations are to be retained in your files  
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