

Beneficiary Form

Group Term Life Insurance

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|--|---|
| Policy Holder: CITY OF DALLAS | Group Number: 301515 |
| Individual Covered Person: (Print Name) | SS#: |

Note: This Beneficiary Designation cancels any prior beneficiary designation and shall be effective on the date received by the Company.

THE BENEFICIARY FOR THE POLICY SHALL BE:

| a) | Primary Beneficiary | Percentage | Relationship to Insured | Address |
|----|------------------------|------------|-------------------------|---------|
| | | | | |
| | | | | |
| b) | Contingent Beneficiary | Percentage | Relationship to Insured | Address |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

INSURED:
Signature _____
Date _____

WITNESS:
Print Name _____
Date _____

Send completed form to:
UnitedHealthcare Specialty Benefits
PO Box 7149
Portland, ME 04112
Phone Inquiries: 1-800-539-0038