

**BENEFICIARY DESIGNATION – DEATH BENEFIT PROGRAM
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES
80 F Street, NW, Washington, DC 20001**

STANDARD BENEFICIARY PROVISION

If you do not name a Beneficiary, or if no named Beneficiary survives, payment of the benefits due under the Group Contract will be made to the Beneficiary or Beneficiaries shown below in the order listed:

- (a) first to the spouse to whom the Insured Member was married when death occurred; or if none
- (b) then equally to the surviving children of the Insured Member, including adopted children, per stirpes; or if none
- (c) then equally to the surviving parents of the Insured Member, or if none
- (d) then equally to the surviving brothers and sisters of the Insured Member; or if none
- (e) then to the estate of the Insured Member.

INSTRUCTIONS

Review the Standard Beneficiary Provision above. If you wish to name a different beneficiary designation, complete items 1-3 below in duplicate. Both copies of this form should then be submitted to the National Office of the American Federation of Government Employees for recording, One copy will be returned to be attached to your certificate. Do not send your certificate with this form.

1. MEMBER INFORMATION:

The National Office of the American Federation of Government Employees is hereby requested to record this beneficiary designation for:

Name of Insured Member _____ Local No. _____
(Please Type or Print)

Member Number _____ Social Security Number _____

2. BENEFICIARY INFORMATION:

I request a Change of Beneficiary under the above Contract to:

Name	Address	Date of Birth	Social Security Number	Relationship to Insured Member

Unless otherwise provided herein, if more than one beneficiary is named, payment will be made in equal shares to the named beneficiaries who survive the Insured Member, if no named beneficiary survives the insured, payment will be made in accordance with the Standard Beneficiary provision of the contract. The right to change this beneficiary designation is reserved to the Insured Member without the consent of the beneficiary or beneficiaries. This Beneficiary Designation operates to change any prior Beneficiary Designation I have made.

3. Dated at _____ this _____ day of _____ 20_____

Witness _____ Insured _____
(Other than Beneficiary)

**4. To be Completed By
The National Office of the American Federation of Government Employees**

This is to certify that a copy of the above Request is on file in the records of the National Office of the American Federation of Government Employees.

Dated at Washington, D.C. this _____ day of _____ 20_____

