Designation of Beneficiary Form



*Social Security Number: *Birth Date (MM/DD/YYYY): *Gender: *Marital S *Street Address: *City: *State: *State: *Zip Code: *Telephone: () *Beneficiary for Death Benefits (Right to change beneficiary is reserved to the insured.) Subject to the terms of the group contract(s), between Mutual of Omaha or a company affiliated with Mutual of Omaha and sa employer, I request that the following beneficiary (beneficiaries) be substituted under said contract(s) as my designated beneficiaries), in lieu of any and all beneficiaries previously named by me. If more than one beneficiary is named, the beneficiaries shall share benefits equally unless otherwise stated below. If indicating percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Unless other expressly provided, if any beneficiary designated below predeceases me, the share which such beneficiary would have receive beneficiary had survived me shall be payable equally to the remaining designated beneficiary or beneficiaries. If no designate beneficiary survives me, the beneficiary shall be determined as prescribed in the group contract(s). *Primary Beneficiary Designation *Relationship to Insured* **Date of Birth Address of Beneficiary Percentage Total: **Date of Birth Address of Beneficiary	- aid ficiary ng benefit rwise
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Agreement and Signature I understand that this Designation of Beneficiary shall apply to all insurance contracts issued to me by Mutual of Omaha or a caffiliated with Mutual of Omaha, unless I make a separate designation for each coverage, either on or after the date of this de I also understand that this Designation of Beneficiary is subject to change as provided in the group contract(s). By signing below, I acknowledge that (a) I understand and agree to the terms of this form as noted above; and (b) this Design Beneficiary is effective as of the date submitted.	esignation.
SIGNATURE OF EMPLOYEE/MEMBER DATE/_	