

Beneficiary Designation Form

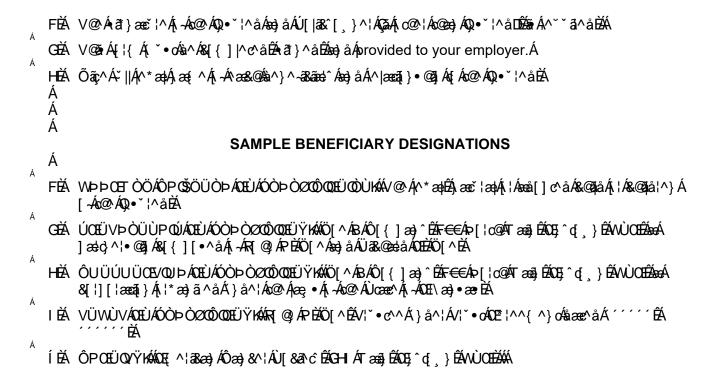
Ú[a&rÂp*{ à^¦Á

P.O. Box 1650 Little Rock, Arkansas 72203-1650

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Cfāå¦^••ÁÁ Ùd^^cÁ Á	ÔãC ÁÁ ÙœeAÁ			ZŒJÁ		Öæê æ[^Á/^ ^] @[} ^Á		
Ú[æx̂ [¸ } ^¦Ápæ(^ÁçÁ, c@¦Ásœ)ÁQ• ˇ¦^åD Bend Chamber of CommerceÁ Policy Number Á							: 50031270	
Á Á Á QÁ@\¦^à^Áå^•ā*}æe^Áo@Á[∥[¸ā]*Áà^}^-æ8ãæd^Qã•DK Δ								
PRIMARY BENEFICIARY(IES) - Will receive proceeds if living at death of Insured:Á								
Last Name	First Name	MI	Social Securi		Birthdate	Relationship	Percentage	
				•		•		
Total =								
CONTINGENT BENEFICIARY(IES) - Will receive proceeds if Primary Beneficiary(ies) are also deceased at death of Insured:Á								
Last Name	First Name	МІ	Social Securi	tv#	Birthdate	Relationship	Percentage	
						•	<u> </u>	
					,	Total =	(Total must equal 100%)	
Á Á Öæer^å/ÁæeÁ Á Á Á Úðil}æeč¦^Áp,-ÁQp•č¦^åÁ Á Úðil}æeč¦^Áp,-ÁQp•č¦^åÁ Á Úðil}æeč¦^Áp,-ÁÚ[æ&c]¸}^¦ÁgæÁp,c@ç¦Ác@æe)ÁQp•č¦^åDÁ								

See Page 2/Reverse Side For Instructions

INSTRUCTIONS



AThis coverage is provided only on employees who are eligible and enrolled in medical plans issued by Providence Health Plans to the Policyowner, the Bend Chamber of Commerce. Benefits are payable to your beneficiary as designated on this form.