Beneficiary Form
Group Term Life Insurance

UnitedHealthcare Specialty Benefits

Policy Holder: **City of Dallas** Group ID # **301515**

Individual Covered Person: _____

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: _____ **WITNESS** _____

Signature Print Name

_____ _____

Date Date

Send completed form to: **UnitedHealthcare Specialty Benefits**
Attn: Beneficiary Management Services
P.O. Box 7149
Portland, ME 04112

Phone Inquiries (800) 539-0038