FLORIDA COMBINED LIFE INSURANCE COMPANY, INC.
5011 GATE PARKWAY, BLDG. 200
JACKSONVILLE, FL 32256

BENEFICIARY AUTHORIZATION FORM

For Group Term Life and/or Accidental Death And Dismemberment Insurance

Please Print.

Employee Name:______________________________

Employee Social Security Number:______________________ Group Number:______________________

Name of Employer:______________________________

Complete all required information in **Sections A and B** below to declare your beneficiary(s). Incomplete information may result in delays in processing your request. Send the white copy to Florida Combined Life Insurance Company, Inc. at the above address and attach the canary copy to your certificate. The full legal name(s) and relationship(s) of the beneficiary(s) are required.

Any questions should be directed to the Customer Service Department at 1-800-333-3256.

A	BENEFICIARY INFORMATION (To be completed by the Insured Employee)

Under and subject to the terms of the above group policy number, I hereby annul and revoke any former beneficiary(s) named by me, and I now designate the following person(s) as beneficiary(s). (If you have forfeited your right to change the beneficiary on your certificate, the irrevocable beneficiary and, if applicable, the absolute assignee must sign in Section B.) If you list more than one beneficiary, assure that the percentage shares for primary beneficiaries total 100% and contingent beneficiaries total 100%. I understand that proceeds will be paid in equal shares or to the survivor(s) when such payment is applicable, if % of share is not indicated. List beneficiary's full name (e.g., "Helen Louise Jones" not "Mrs. H. L. Jones").

	Last Name	First Name	MI	Relationship to Insured	% of Share
Primary					
Primary					
Primary					
Primary					
Contingent					
Contingent					
Contingent					
Contingent					

B	SIGNATURES (To be signed by the Insured Employee and Witness and, when applicable, the Irrevocable Beneficiary and Absolute Assignee)

Florida Combined Life Insurance Company, Inc. will not process the beneficiary(s) designation without the appropriate signatures.

Employee's signature: ______________________________ Date: ______________

Irrevocable Beneficiary signature: ______________________________ Date: ______________

Absolute Assignee signature: ______________________________ Date: ______________

Witness signature: ______________________________ Date: ______________