



Underwritten by
 United of Omaha Life Insurance Company
 Mutual of Omaha Insurance Company
 Mutual of Omaha Affiliates

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 Omaha, NE 68175-0001
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Designation of Beneficiary Form

Employer/Group Section (To be completed by the employer/plan administrator. Required fields are marked with an asterisk(*).)

*Employer/Group Name: MMIA - Group ID: G000CJ7W
 CITY/TOWN of _____

Employee/Member Section (Please print clearly. Required fields are marked with an asterisk(*).)

*Last Name: _____ *First Name: _____ MI: _____
 *Social Security Number: _____ *Birth Date (MM/DD/YYYY): _____ *Gender: _____ *Marital Status: _____
 *Street Address: _____ Email Address: _____
 *City: _____ *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 said employer, I request that the following beneficiary (beneficiaries) be substituted under said contract(s) as my designated beneficiary (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 benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Unless otherwise expressly provided, if any beneficiary designated below predeceases me, the share which such beneficiary would have received if such beneficiary had survived me shall be payable equally to the remaining designated beneficiary or beneficiaries. If no designated beneficiary survives me, the beneficiary shall be determined as prescribed in the group contract(s).

Primary Beneficiary Designation		Employer-Paid Coverage <input type="checkbox"/>		Employee-Paid Coverage <input type="checkbox"/>		All <input type="checkbox"/>
Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)		Benefit Percentage (%) *
Percentage Total (*whole numbers only):						100%

Secondary Beneficiary Designation		Employer-Paid Coverage <input type="checkbox"/>		Employee-Paid Coverage <input type="checkbox"/>		All <input type="checkbox"/>
Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)		Benefit Percentage (%) *
Percentage Total (*whole numbers only):						100%

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 company affiliated with Mutual of Omaha, unless I make a separate designation for each coverage, either on or after the date of this designation. 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 Designation of Beneficiary is effective as of the date submitted.

Signature of Employee/Member _____ Date _____