BENEFICIARY FORM

GROUP TERM LIFE INSURANCE
AND
COLLEGE TRAVEL ACCIDENT INSURANCE

PLEASE COMPLETE THIS FORM AND RETURN IT TO THE

BENEFITS OFFICE, HINMAN BOX 6042, DARTMOUTH COLLEGE, HANOVER, NEW HAMPSHIRE 03755

YOUR LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____

BENEFICIARY	ADDRESS	PRIMARY OR CONTINGENT* *(circle one)*	PERCENT OF BENEFIT *(if two or more persons)*
NAME			
SOCIAL SECURITY NUMBER			
RELATIONSHIP TO YOU		P* C*	
NAME			
SOCIAL SECURITY NUMBER			
RELATIONSHIP TO YOU		P C	
NAME			
SOCIAL SECURITY NUMBER			
RELATIONSHIP TO YOU		P C	
NAME			
SOCIAL SECURITY NUMBER			
RELATIONSHIP TO YOU		P C	
NAME			
SOCIAL SECURITY NUMBER			
RELATIONSHIP TO YOU		P C	

**P= Primary beneficiary, or first choice of beneficiary. NOTE: If you would like to divide coverage among more than one primary beneficiary, please indicate the percentage you would like each to receive.*

**C= Contingent beneficiary, or second choice if primary beneficiary or beneficiaries are no longer living.*

In accordance with the conditions of the Group Life Insurance Contract through Dartmouth College and College Travel Accident Insurance, I hereby revoke any previous designation of beneficiary and contingent beneficiary and designate as beneficiary the names above.

All decisions upon questions of fact, which are made in good faith by the Insurance Company in determining the identity of any unnamed person herein and which are based on proof by affidavit or other written evidence satisfactory to it, shall be conclusive and shall fully protect the Insurance Company in acting in reliance thereon.

I reserve the right to change this designation at any time.

SIGNATURE: _____ DATE: _____