GROUP TERM LIFE INSURANCE *AND* COLLEGE ACCIDENT INSURANCE

Please complete this form and return it to: The Office of Human Resources, Benefits Department
Hinman Box 6042, Dartmouth College, Hanover, NH 03755

Dartmouth College Employee Information:

First Name: Last Name: Middle Initial:

Social Security Number: Date of Birth: Net ID:

Beneficiary Information:

		Primary or Contingent* (circle one)		% of Benefit (if 2 or more persons)
Name:				
Social Security Number:				
Date of Birth:	Relationship to You:	P*	C*	
Address:				
Name:				
Social Security Number:				
Date of Birth:	Relationship to You:	P*	C*	
Address:				
Name:				
Social Security Number:				
Date of Birth:	Relationship to You:	P*	C*	
Address:				

*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 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 decesions 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 Companyin acting reliance thereon.

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

Signature: Date: