



Designation of Beneficiary

Before executing this form refer to other side. Please keep a copy for your records.

Group Contract Holder Name AOUINAS COLLEGE	Group Contract Number 725158
Employee/Retiree Name and Address	Employee/Retiree Social Security Number

Subject to the terms of the above numbered Group Contract(s), I request that any sum becoming payable by reason of my death be payable to the following beneficiary(ies). It is my understanding that this designation shall operate so as to revoke all designations of beneficiary and all elections of optional methods of settlement previously made by me under said Contract(s).

This Designation of Beneficiary is subject to all "Conditions" shown on the reverse side of this form.

Employee/Retiree Signature	Date
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Beneficiary Name and Address	<input checked="" type="checkbox"/> Primary Beneficiary
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Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage
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Beneficiary Name and Address	(Please check one) <input type="checkbox"/> Primary Beneficiary <i>or</i> <input type="checkbox"/> Contingent Beneficiary*
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Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage
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Beneficiary Name and Address	(Please check one) <input type="checkbox"/> Primary Beneficiary <i>or</i> <input type="checkbox"/> Contingent Beneficiary*
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Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage
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Beneficiary Name and Address	(Please check one) <input type="checkbox"/> Primary Beneficiary <i>or</i> <input type="checkbox"/> Contingent Beneficiary*
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Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage
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* **Contingent Beneficiary**(ies) will only receive proceeds if all Primary Beneficiaries have predeceased the insured.

(If more than one named, the beneficiaries shall share equally unless otherwise indicated above.) If this Designation of Beneficiary refers only to a Group Life Insurance contract and if I am also insured for Group Accidental Death coverage, this designation shall apply to both contracts unless expressly stated above.

Conditions

- Unless otherwise expressly provided in this Designation of Beneficiary form, if any named beneficiary predeceases me, the life proceeds shall be payable equally to the remaining named beneficiary or beneficiaries. If no named beneficiary survives me, any sum becoming payable under said Group Contract(s) by reason of my death shall be payable as prescribed in said Group Contract(s).
- If this Designation of Beneficiary provides for payment to a trustee under a trust agreement, Aetna Life Insurance Company shall not be obliged to inquire into the terms of the trust agreement and shall not be chargeable with knowledge of the terms thereof.

Payment to and receipt by the trustee shall fully discharge all liability of said Insurance Company to the extent of such payment.

Instructions

- Please use black ink only to complete this form.
- If a mistake is made, line out the erroneous information, add the correct information and initial the correction. **The printed material on this form should not be deleted or altered in any way.**
- In all cases, the relationship of the beneficiary should be included with the beneficiary designations.
- If beneficiary is to be contingent, be sure to check the appropriate box. A contingent beneficiary will receive benefits only if the primary beneficiary(ies) do not survive the insured.
- If a married woman is named beneficiary, her full given name should be shown.
For example: Mary J. Smith, not Mrs. John J. Smith, likewise, if the form is to be signed by a married woman, she should sign her given name.
- If a minor child is named beneficiary, the date of birth along with the social security number must be given.
- When two or more are named beneficiaries, and they are not to share the benefits equally, enter the percentage each beneficiary is to receive on the form in the space provided. **Dollars and cents should not be specified.**
- If a trustee is named beneficiary, show the name and address of the trustee and the date of the trust agreement.
For example: The John J. Smith Revocable Life Insurance Trust with the Trust Company of Hartford, Connecticut, 456 Pearl Street, Hartford, CT 06110, as Trustee under Trust Agreement Dated January 1, 1994.

For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison, and substantial civil penalties. Many other states have similar laws. **Attention Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.**