

CHANGE OF BENEFICIARY FORM

Insured Person's Name: _____ Social Security Number: _____

Group Policyholder Name: _____

THE UNDERSIGNED INSURED PERSON HEREBY REVOKES ANY PREVIOUS BENEFICIARY DESIGNATION WITH RESPECT TO ANY DEATH BENEFIT PROCEEDS PAYABLE AT THE DEATH OF THE INSURED PERSON. BENEFITS WILL BE PAID IN A LUMP SUM AS FOLLOWS:

Name _____ Percentage _____ DOB _____ Relationship _____

Name _____ Percentage _____ DOB _____ Relationship _____

Name _____ Percentage _____ DOB _____ Relationship _____

Name _____ Percentage _____ DOB _____ Relationship _____

Name _____ Percentage _____ DOB _____ Relationship _____

Name _____ Percentage _____ DOB _____ Relationship _____

Name _____ Percentage _____ DOB _____ Relationship _____

I understand any beneficiary change shown above will take effect on the date I signed below, whether or not I am living when this form is received by Bay Bridge Administrators, LLC. This change is without prejudice to Bay Bridge Administrators, LLC for payment they may make or action they may take before it receives this form. Also, I reserve the right to change any above beneficiary designation unless I have indicated that it is "irrevocable". I understand the Certificate of Insurance requirements apply.

* If a trust is named as the beneficiary, the trustee's name and address must also be provided in the section. If the trustee changes, I must inform Bay Bridge Administrators, LLC and provide them with the updated information.

THIS BENEFICIARY DESIGNATION CANCELS AND SUPERSEDES ALL PREVIOUS REVOCABLE DESIGNATIONS.

Insured Person Signature

Date

Witness Signature

Date