Underwritten by:
Unum Life Insurance Company of America
2211 Congress Street, Portland, ME 04122

FCMM Benefits & Retirement
901 East 78th Street, Minneapolis, MN 55420
Group Short and Long Term Disability Insurance
with Term Life/AD&D
Enrollment & Update Form
Policy #930391/Div #001

Form 102: Beneficiary Designation

Please complete the beneficiary information on this form. If you wish to change your beneficiary at any time please complete a new Form 102. The form with the most recent signature date will replace all other elections or directions. Beneficiary designation will affect your LTD Survivor Benefit and Life/AD&D Insurance coverage. The Form 102 must be mailed in its originally signed form to FCMM's office to be filed for insurance purposes.

Employee Social Security Number _______ - _____ - __________

Gender ☐ M ☐ F

Date of Birth (mm/dd/yyyy) ____ / ____ / ________

Employee First Name ________________________ **M.I.** _____ **Last Name** ________________________

Phone Number ________________________

Email Address ________________________

(I) PRIMARY BENEFICIARY(S) (REQUIRED)

Name *(last name, first, middle initial)*:	Relation to You:	Benefit %:
(1)		
(2)		

**Total of all Primary Beneficiary designations must equal 100%.*

(II) CONTINGENT BENEFICIARY(S) (REQUIRED)

If the beneficiary(ies) named above are not living, then pay:

Name *(last name, first, middle initial)*:	Relation to You:	Benefit %:
(1)		
(2)		
(3)		
(4)		

**Total of all Contingent Beneficiary designations must equal 100%.*

I certify all statements I provided are true to the best of my knowledge and belief, and I understand a copy of this form will be made available to me at my request. I have read and understand the “Limitations and Exclusions” included with this enrollment form.

Employee Signature: ________________________________ **Date:** ________________

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