UnitedHealthcare®
A UnitedHealth Group Company

Beneficiary Form

Group Term Life Insurance

Policy Holder: (Employer) **HPS Mechanical, Inc.**	**Group Number: 303617**
Individual Covered Person: (Print Name)	SS#:

Note: This Beneficiary Designation cancels any prior beneficiary designation and shall be effective on the date received by the Company.

THE BENEFICIARY FOR THE POLICY SHALL BE:

a)	Primary Beneficiary	Percentage	Relationship to Insured	Address
b)	**Contingent Beneficiary**	**Percentage**	**Relationship to Insured**	**Address**

INSURED: _____ WITNESS: _____

Signature _____ Print Name _____

Date _____ Date _____

Send completed form to the Benefits Office in Human Resources.