Ensure Highlight Fields, found in the top right corner, has been selected. Data fields will be highlighted when this feature is enabled. Click to check a box or enter data in a field; use the Tab key to move to the next field. Complete and print the form; sign and submit to EPIC at the address or fax number below.

EPIC LIFE INSURANCE

Beneficiary Designation Form

☐ New Employee ☐ Change in Beneficiary

If you wish to make a beneficiary designation or change your existing beneficiary for your Life, AD&D, or Short-term Disability Survivor Benefit coverage, please complete this form and return it to EPIC's Life and Disability Department using the address or fax number below. Please indicate your primary and contingent beneficiary(ies), if any, to whom proceeds shall be payable upon your death.

Primary:

(1) Name _____ Relationship _____

Address _____

City State ZIP

(2) Name _____ Relationship _____

Address _____

City State ZIP

Contingent:

(1) Name _____ Relationship _____

Address _____

City State ZIP

(2) Name _____ Relationship _____

Address _____

City State ZIP

If more than one primary or contingent beneficiary is designated, payment of proceeds shall be made in equal shares to the named beneficiary(ies) surviving the employee, unless otherwise noted in the designation. Contingent beneficiaries are only entitled to such proceeds if no primary beneficiary survives the employee. If no designated beneficiary survives the employee, payment shall be made to the employee's estate, unless otherwise noted in the group Life insurance policy. The above designation supersedes all prior designations, if any, regarding your Life, AD&D, or Short-term Disability Survivor Benefit coverage.

Applicant Name (print) _____

Address _____

City State ZIP

Group Number 3180

Applicant Signature _____ Date Signed _____ (mm/dd/yyyy)

P.O. Box 8430 | Madison, WI 53708-8430 | *www.epiclife.com*
toll-free: 1-800-520-5750 | fax: 1-800-236-7610
A Subsidiary of WPS Health Insurance