MEDICO®
LIFE AND HEALTH INSURANCE COMPANY

P.O. Box 10386
Des Moines, IA 50306-0386
Toll Free 1-800-228-6080

REQUEST FOR CHANGE OF BENEFICIARY

(Group Life Insurance)

Mail to above address.

Group Policy Number _____ Insured's Name _____

Group Certificate Number _____ Group Name _____

The Company is hereby requested to cancel all previous designations of the beneficiary of the life insurance (and accidental death benefits if any) provided on the life of the above named Insured by the above numbered policy and evidenced by the above numbered certificates, and to change the beneficiary of such insurance as designated below:

FIRST BENEFICIARY(IES)

(Full Name)	(Date of Birth)	(Relationship)

If living, otherwise to SECOND BENEFICIARY(IES)

(Full Name)	(Date of Birth)	(Relationship)

Unless otherwise expressly provided herein, if two or more persons are named as beneficiaries of the same class, either first or second, then such beneficiary shall share equally in the proceeds to the exclusion of the beneficiaries in subsequent classes, and upon the death of one or more of them, payment shall be made to the survivor or survivors of the beneficiaries in such class. If the beneficiary or beneficiaries in any such class survive the Insured and then die before all of the proceeds can be paid, then the proceeds or the discounted value of the proceeds then remaining unpaid, as the case may be, shall be paid in one sum to the estate of the last surviving beneficiary in such class. If no beneficiary in any such class survives the insure, the proceeds shall be paid in one sum according to the terms of the policy to the estate of the undersigned.

The right to revoke this designation at any time while the insurance evidenced by this certificate is in force is hereby reserved, in accordance with the provisions of the policy.

The Company, in determining the existence, identity, ages or any other facts relating to any persons designated as beneficiaries herein, either as a class or otherwise, may rely solely upon any affidavit or other evidence deemed satisfactory by The Company and each and every payment made by The Company in reliance thereon shall, to the extent of such payment, be a valid discharge of The Company's obligation under the above numbered policy.

If the beneficiary be a Trustee and the trust be terminated or the insurance evidenced by this Certificate withdrawn and notice thereof given The Company, then payment and receipt by my Executors, Administrators, or designated beneficiary, if I shall hereafter designate a new beneficiary in accordance with the above numbered Policy, shall be a full discharge of the liability of The Company under the said Policy.

Dated at the City of _____ , State of _____

this _____ day of _____ , 20_____ .

(Signature of Witness)	(Signature of Individual Insured) or, if insurance has been assigned, of assignee

DO NOT SIGN BELOW THIS LINE

The Company hereby acknowledges the foregoing request for change of beneficiary, subject to the express condition that the insurance evidenced by this Certificate is in force on the date of the request.

(Date)	(LRIC Authorized Signature)

INSTRUCTIONS

1. **Complete this form and send it to The Company. One copy will be acknowledged and returned to you.**
2. **When your copy is returned, please attach it to the certificate.**
3. **If such insurance has been assigned, assignee must sign in ink.**
4. **Do NOT send certificate, unless requested by The Company.**

WHITE - HOME OFFICE CANARY - EMPLOYEE