



Beneficiary Designation Form

for American Heritage Life Insurance Company's
Group Accident and Group Critical Illness Plans

Workplace Division

Work Location _____

Name _____ Social Security Number _____

This form names my beneficiaries for my: Group Accident and Group Critical Illness plans. Beneficiary designations must total 100% for each plan.

☐ If you want the same beneficiaries for both plans, check here and fill out the first beneficiary section only.

Group Accident Beneficiary

1. Name: _____ Social Security Number: _____ Date of Birth: _____ Relationship: _____ %
Address: _____ City: _____ State: _____ Zip: _____
2. Name: _____ Social Security Number: _____ Date of Birth: _____ Relationship: _____ %
Address: _____ City: _____ State: _____ Zip: _____
3. Name: _____ Social Security Number: _____ Date of Birth: _____ Relationship: _____ %
Address: _____ City: _____ State: _____ Zip: _____
4. Name: _____ Social Security Number: _____ Date of Birth: _____ Relationship: _____ %
Address: _____ City: _____ State: _____ Zip: _____ = 100 %

Group Critical Illness Beneficiary

1. Name: _____ Social Security Number: _____ Date of Birth: _____ Relationship: _____ %
Address: _____ City: _____ State: _____ Zip: _____
2. Name: _____ Social Security Number: _____ Date of Birth: _____ Relationship: _____ %
Address: _____ City: _____ State: _____ Zip: _____
3. Name: _____ Social Security Number: _____ Date of Birth: _____ Relationship: _____ %
Address: _____ City: _____ State: _____ Zip: _____
4. Name: _____ Social Security Number: _____ Date of Birth: _____ Relationship: _____ %
Address: _____ City: _____ State: _____ Zip: _____ = 100 %

This Beneficiary Designation Form shall revoke and take the place of any beneficiary forms I have completed before this date. I understand that I have the right to change this Beneficiary Designation Form at any time.

Associate's Signature _____ Date _____

PLEASE PROCEED TO THE BACK OF THIS PAGE TO FILL OUT YOUR SECONDARY (ALTERNATE) BENEFICIARIES.

**IF THE BENEFICIARY LISTED ON THE PREVIOUS PAGE DOES NOT SURVIVE ME,
THESE ARE MY SECONDARY (ALTERNATE) BENEFICIARIES**

Work Location_____

Name_____ Social Security Number_____

This form names my beneficiaries for my: Group Accident and Group Critical Illness plans. Beneficiary designations must total 100% for each plan.

☐ **If you want the same alternate beneficiaries for both plans, check here and fill out the first beneficiary section only.**

Group Accident Beneficiary

1. Name: _____ Social Security Number: _____ Date of Birth: _____ Relationship: _____ %

Address: _____ City: _____ State: _____ Zip: _____

2. Name: _____ Social Security Number: _____ Date of Birth: _____ Relationship: _____ %

Address: _____ City: _____ State: _____ Zip: _____

3. Name: _____ Social Security Number: _____ Date of Birth: _____ Relationship: _____ %

Address: _____ City: _____ State: _____ Zip: _____

4. Name: _____ Social Security Number: _____ Date of Birth: _____ Relationship: _____ %

Address: _____ City: _____ State: _____ Zip: _____ = 100 %

Group Critical Illness Beneficiary

1. Name: _____ Social Security Number: _____ Date of Birth: _____ Relationship: _____ %

Address: _____ City: _____ State: _____ Zip: _____

2. Name: _____ Social Security Number: _____ Date of Birth: _____ Relationship: _____ %

Address: _____ City: _____ State: _____ Zip: _____

3. Name: _____ Social Security Number: _____ Date of Birth: _____ Relationship: _____ %

Address: _____ City: _____ State: _____ Zip: _____

4. Name: _____ Social Security Number: _____ Date of Birth: _____ Relationship: _____ %

Address: _____ City: _____ State: _____ Zip: _____ = 100 %

This Beneficiary Designation Form shall revoke and take the place of any beneficiary forms I have completed before this date. I understand that I have the right to change this Beneficiary Designation Form at any time.

Associate's Signature _____ **Date** _____

INSTRUCTIONS:

Complete this form and return it to Walmart Customer Care Unit, P.O. Box 41488, Jacksonville, FL 32203-1488.

NOTES:

- 1) You must fill in beneficiary names before signing.
- 2) Cross-outs and white-outs will invalidate your designation unless each of these changes are initialed.
- 3) If you complete only one row we will assume you want the same beneficiary for both plans.
- 4) Complete additional forms if you have more than four beneficiaries per plan.