Attestation:

- Additional Beneficiaries

Desoto Independent School District 6500772

INFORMATION ABOUT YOU.

Print your name (first, middle initial, last)	Social Security Number	Date of birth (MM/DD/YYYY)

Read This Page Carefully

As the employee, you must complete, sign and submit this form to your employer

If your beneficiaries are the same for each product (Hospital Indemnity Plan), please check here and ***only*** enter your beneficiary information ***once***. ☐ Yes ☐ No

1. Please list Beneficiaries for the Hospital Indemnity plan(s). You can list up to five beneficiaries per product.
The percent grand total must equal 100% and cannot be greater than or less than 100%.

a. Beneficiary (please print): % amount for Beneficiary:

Relationship: Social Security Number:

b. Beneficiary (please print): % amount for Beneficiary:

Relationship: Social Security Number:

c. Beneficiary (please print): % amount for Beneficiary:

Relationship: Social Security Number:

d. Beneficiary (please print): % amount for Beneficiary:

Relationship: Social Security Number:

e. Beneficiary (please print): % amount for Beneficiary:

Relationship: Social Security Number:

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Attestation: I understand that, to the extent permitted by state law, false statements may result in the denial of claims or in my insurance coverage being void as of is effective date with no benefits payable. I understand conditions disclosed on this form may be subject to all conditions of my employer's plan. My signature indicates that I have reviewed all information and statements on this form for completeness and accuracy. **I acknowledge that I have read the Privacy Notice and Misrepresentation Section during the enrollment process and know that I have a right to receive a copy of this authorization upon request.** I agree that a copy of this authorization is as valid as the original.

Employee name (please print)

Employee signature Today's date (MM/DD/YYYY)