Beneficiary Designation Form

Please retain a copy for the insured.

ADVANCE Insurance Company of Kansas SM

advanceinsurance.com

Employer ______ AICK Group Number ______ Class ______

Section 1 – Insured Information (always complete this section)

First Name ______ MI ______ Social Security Number ___-___-___

Last Name ______ Suffix ______

Section 2A – Primary Beneficiary Designation

This beneficiary designation will apply to all benefits with Advance Insurance Company of Kansas (AICK). If it does not, you should indicate which benefits the change applies to:

- ☐ Basic Term Life and Accidental Death & Dismemberment (AD&D)
- ☐ Voluntary Term Life (and AD&D, if applicable)
- ☐ Voluntary Employee Accident/Family Accident

Primary beneficary information (receives the benefit upon death of the insured): The proceeds will be paid in equal shares to the persons shown below unless you state otherwise. If you need more space, attach a separate sheet with complete information. You must sign and date the separate sheet.

First Name ______ MI ______ Relationship to Applicant ______

Last Name ______ Suffix ______ Date of Birth ___/___/___ or Age ______

First Name ______ MI ______ Relationship to Applicant ______

Last Name ______ Suffix ______ Date of Birth ___/___/___ or Age ______

Section 2B – Contingent Beneficiary Designation (you must complete Section 2A if you fill out this section)

Contingent beneficary information (receives the benefit only if the beneficiary(ies) in Section 2A is/are deceased): If there is more than one Contingent Beneficiary listed below, the proceeds will be paid in equal shares unless you state otherwise. If you need more space, attach a separate sheet with complete information. You must sign and date the separate sheet.

First Name ______ MI ______ Relationship to Applicant ______

Last Name ______ Suffix ______ Date of Birth ___/___/___ or Age ______

First Name ______ MI ______ Relationship to Applicant ______

Last Name ______ Suffix ______ Date of Birth ___/___/___ or Age ______

Section 3 – Authorization (signature and date are required)

Your signature required

Insured Employee Signature ______ Date Signed ___/___/___

Email completed form to: csc-advance@advanceinsurance.com; or fax to 785-290-0727

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