



Underwriting Company (herein called the "Company")*:

- CNA Group Life Assurance Company
- Continental Assurance Company
- Continental Casualty Company

Beneficiary Designation Form

Name of Insured _____

Policyholder Name _____

I hereby direct that the beneficiary designation(s) below apply to the following policy numbers:

<input type="checkbox"/> Group Short Term Disability # _____ <input type="checkbox"/> Group Long Term Disability # _____ <input type="checkbox"/> Voluntary Long Term Disability # _____ <input type="checkbox"/> Voluntary AD&D # _____	<input type="checkbox"/> Group Term Life/AD&D # _____ <input type="checkbox"/> Voluntary Term Life # _____ <input type="checkbox"/> Group Travel Accident # _____ <input type="checkbox"/> Other _____
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As a covered employee, you have the right to select a beneficiary in accordance with the provisions of your policy. You may also have the right to change the beneficiary designated. If more than one beneficiary is designated, payment of the death benefit will be made in equal shares to each of the designated beneficiaries which survive the insured, unless some other allocation is specified by you below in accordance with the provisions of the policy. **If no designated beneficiary survives the insured, settlement will be made in accordance with the terms of the policy.**

ONE BENEFICIARY ONLY OR PRIMARY AND CONTINGENT BENEFICIARY

(The share of the deceased primary beneficiary will be paid to the contingent beneficiary)

Beneficiary Name: _____ Relationship _____

Social Security # _____ Phone # & Address _____

Contingent Beneficiary: _____ Relationship _____

Social Security # _____ Phone # & Address _____

TWO OR MORE BENEFICIARIES

(The share of any deceased beneficiary to be paid in equal shares to the survivors, or to the survivor)

Beneficiary Name: _____ Relationship _____ % of benefit _____

Social Security # _____ Phone # & Address _____

Beneficiary Name: _____ Relationship _____ % of benefit _____

Social Security # _____ Phone # & Address _____

Beneficiary Name: _____ Relationship _____ % of benefit _____

Social Security # _____ Phone # & Address _____

TRUSTEE BENEFICIARY

Name: _____ as Trustee, or his successor or successors in trust,

under trust agreement between _____ dated _____, and supplements or amendments thereto, if said agreement shall then be in force and, if not, to the executors, administrators or assigns of the insured.

In no event shall the Company be responsible for the application or disposition by the Trustee of the sum payable. The payment to and receipt by the Trustee shall be a full discharge of the liability of the Company for any amount paid to such Trustee.

You may have the right to change your beneficiary. The written consent is needed from: 1) any irrevocable beneficiary, or 2) your spouse, if you are a resident of AZ, CA, ID, LA, NV, NM, TX, WA or WI and you name someone other than your spouse as beneficiary.

Signature of Insured _____ Date _____

Signature of Spouse or Irrevocable Beneficiary _____ Date _____

* Unless indicated otherwise above, the underwriting company will be CNA Group Life Assurance Company. If CNA Group Life Assurance Company is not authorized to issue coverage in connection with the above policy, then coverage will be provided by Continental Casualty Company or Continental Assurance Company.