UNIMERICA LIFE INSURANCE COMPANY OF NEW YORK

Beneficiary Form - Group Term Life Insurance

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Important Note: This on the date received by	Beneficiary Designation the Company	canc	els any prior bene	ficiary des	signation an	d sha	all be effectiv
Policyholder:							
Individual Covered Person		SSN# and DOB:			Phone#		
Street Address (include apartment # as application		able)	City		State		Zip
THE BENEFICIARY I	FOR THE POLICY SH	ALL E	BE:				
	P	rimar	y Beneficiary				
Name	Address		SSN# and DOB	Relation Covered	ship to the Person		
In the event, and on	ly in the event, that all Pr payable to the f		Beneficiaries predeng Contingent Bene		, then the pi	ocee	ds shall be
	Con	tinge	ent Beneficiary				
Name	Address		SSN# and DOB	Relation Covered	ship to the Person	Ben Ben	f Death lefit Payable to leficiary (must ll 100%)
an application for instruction conceals for the purport fraudulent insurance five thousand dollars	vingly and with intent turance or statement of ose of misleading, infoact, which is a crime, a and the stated value or	claim ormation and sh f the c	ontaining any non concerning an an all also be subject that also be subject that all also be subject that all also be such such that all all all all all all all all all a	naterially y fact ma et to a civ ch violatio	false inforterial there il penalty non.	mation to, conto	on, or ommits a exceed
Insured's Printed Nan	ne:						
	one person in a group of the then unless I otherwise dire						

Contingent beneficiaries, then unless I otherwise direct in writing above, each designated beneficiary in a group shall share equally in the amount to be paid under the covering policy. In the event any designated beneficiary (ies) in a group predeceases me, then the remaining beneficiary (ies) in that group of beneficiaries shall share equally in the life insurance proceeds to be paid under the policy.