UNIMERICA LIFE INSURANCE COMPANY OF NEW YORK

Beneficiary Form - Group Term Life Insurance

Important Note: This Beneficiary Designation cancels any prior beneficiary designation and shall be effective on the date received by the Company			
Policyholder:			
Individual Covered Person	SSN# and DOB:	Phone#	
Street Address (include apartment # as applicable)	City	State	Zip

THE BENEFICIARY FOR THE POLICY SHALL BE:

Primary Beneficiary				
Name	**Address**	**SSN# and DOB**	**Relationship to the Covered Person**	**% of Death Benefit Payable to Beneficiary (must total 100%)**

In the event, and only in the event, that all Primary Beneficiaries predecease me, then the proceeds shall be payable to the following Contingent Beneficiaries

Contingent Beneficiary				
Name	**Address**	**SSN# and DOB**	**Relationship to the Covered Person**	**% of Death Benefit Payable to Beneficiary (must total 100%)**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Insured's Signature:_____ **Date:** _____

Insured's Printed Name: _____

In case I name more than one person in a group of beneficiaries, whether as the Primary beneficiaries or as the 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.