



Beneficiary Designation Form

The Lincoln National Life Insurance Company
PO Box 2649, Omaha, NE 68103-2649
toll free (800) 423-2765 Fax (800) 462-4660
www.LincolnFinancial.com

Policyholder/Employer Diocese of Great Falls- Billings	Policy Number(s) 10252785
Employee Name	Employee Social Security or Certificate Number
Employee Address (Street, City, State)	Employee Telephone Number

WHO ARE YOUR BENEFICIARIES?

It is very important to clearly indicate your primary beneficiary(ies) and contingent beneficiary(ies). Proceeds are paid to contingent beneficiary(ies) only if there is no surviving primary beneficiary(ies). If multiple primary beneficiaries or contingent beneficiaries are named and no percentage distribution is noted, then any proceeds payable to such beneficiaries will be split equally. If more space is needed to list your beneficiaries please attach a sheet to this form. **The beneficiary(ies) named on this form will be valid for all basic, optional, and/or voluntary group term life and AD&D, Accident and Critical Illness coverages unless otherwise indicated by you. The beneficiary designation may not go into effect until this form is signed and dated by you. Page 2 of this form includes examples of how to complete this form.**

PRIMARY BENEFICIARY(IES)

Primary Beneficiary's Name and Address	Social Security Number	Relationship to You	Date of Birth	Percentage: Must equal 100%
Name: Address:				
Name: Address:				
Name: Address:				

CONTINGENT BENEFICIARY(IES): Contingent beneficiaries will only receive benefit if there are no surviving primary beneficiaries.

Contingent Beneficiary's Name and Address	Social Security Number	Relationship to You	Date of Birth	Percentage: Must equal 100%
Name: Address:				
Name: Address:				
Name: Address:				

Community Property State Consent for residents of Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin. If you are married, live in a community property state, and name someone other than your spouse as beneficiary, you may have your spouse sign below to waive his or her rights to any community property interest in the benefit.

As the Insured's spouse, I do hereby consent to the beneficiary designation(s) indicated on this form and waive any rights that I may have to the proceeds of such insurance under applicable community property laws.

Signature of Spouse

Date

Signature of Employee

Date