Sagicor

APPOINTMENT OF BENEFICIARY FORM (PENSIONS)

Group Policyholder

Policyholder's Address

Plan Number **Certificate Number**

Employee Name

____

First Name ***Initial*** ***Last Name***

The undersigned hereby revokes any beneficiary designation or direction of payment previously made in respect to the proceeds payable on the death of the insured Employee under the above policy(ies) and directs that such proceeds be paid to:

BENEFICIARY					**DATE OF BIRTH**		
Miss Mrs. Mr.	**SURNAME**	**CHRISTIAN NAME(S)**	**RELATIONSHIP**	**%**	Day	Month	Year
BENEFICIARY					**DATE OF BIRTH**		
Miss Mrs. Mr.	**SURNAME**	**CHRISTIAN NAME(S)**	**RELATIONSHIP**	**%**	Day	Month	Year
BENEFICIARY					**DATE OF BIRTH**		
Miss Mrs. Mr.	**SURNAME**	**CHRISTIAN NAME(S)**	**RELATIONSHIP**	**%**	Day	Month	Year

Signed at ____________________________ this ____________day of _____________________ , _______

____ ________________________________
Signature of Employee Signature of Employer

____ ________________________________
Witness other than Beneficiary Witness Occupation

____
Witness Address

____
Contact Number (s)

PLEASE COMPLETE IN DUPLICATE AND FORWARD BOTH COPIES TO SAGICOR LIFE INC