GUARDIAN®

□ Northeast Regional Office
P.O. Box 26050
Lehigh Valley, PA 18002-6050

□ Midwest Regional Office
P.O. Box 8012
Appleton, WI 54912-8012

□ Bridgewater Office
P.O. Box 425
E. Bridgewater, MA 02333-0425

□ Western Regional Office
P.O. Box 2454
Spokane, WA 99210-2454

Beneficiary Designation/ Change Form

PLEASE TYPE or PRINT CLEARLY. *(The entire form, properly completed, signed and dated by the Insured, must be submitted or the changes cannot be processed.)*

EMPLOYER/PLANHOLDER NAME:	GROUP NUMBER
EMPLOYEE NAME (LAST, FIRST, M.)	SOCIAL SECURITY #
EMPLOYEE HOME ADDRESS (STREET, CITY, STATE, ZIP)	

I AUTHORIZE Guardian or my employer to record and consider the individuals/instructions that I have named on this form as beneficiaries for benefits under the applicable employee benefits plan.
(PLEASE COMPLETE THE APPROPRIATE SECTIONS ONLY.)

BENEFICIARY INFORMATION: *(Complete to designate a beneficiary or change the beneficiary designation); Include full proper name, relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wife, friend, son, daughter.*

Primary: 1) _____ _____ _____ _____ _____
Name | Date of Birth | Relationship | Social Security # | %

_____
Address

2) _____ _____ _____ _____ _____
Name | Date of Birth | Relationship | Social Security # | %

_____
Address

Contingent: 1) _____ _____ _____ _____ _____
Name | Date of Birth | Relationship | Social Security # | %

_____
Address

2) _____ _____ _____ _____ _____
Name | Date of Birth | Relationship | Social Security # | %

_____
Address

If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan.

SIGNATURE OF INSURED	SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY)	DATE

ALL SIGNATURES MUST BE IN INK

CHANGE IN BENEFICIARY'S NAME *(Complete only if the name has been legally changed.)*

FROM (WAS)	TO (NOW IS)	SOCIAL SECURITY #	DATE

CHANGE IN INSURED'S NAME *(Complete only if the name has been legally changed.)*

FROM (WAS)	TO (NOW IS)	SOCIAL SECURITY #	DATE

SIGNATURE OF INSURED	DATE

ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM

THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY.

This is to certify that the following changes have been recorded in connection with the insurance for the above named insured.

☐ The BENEFICIARY has been changed ☐ The NAME of the BENEFICIARY has been changed ☐ New Employee

Recorded by _____ Date _____

GG-17 (9/06)

FORWARD FORM TO THE PLANHOLDER OR GUARDIAN LIFE INSURANCE FOR RECORDING