

Toll Free: (855) 377-5433

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**THIS FORM SHOULD BE COMPLETED AND ATTACHED TO THE CLAIM FORM
FOR EXTENDED INSURANCE BENEFITS (EIB)**

INSTRUCTIONS:

1. Please print. Form must be completed, signed and dated in ink.
2. Do not erase, attempt to make corrections, or use white-out; use a new form. If strike through is made; initial change.
3. If the rights under this certificate have been transferred, the Owner must sign the form.
4. **The original should be submitted with your EIB claim.**
5. The change in beneficiary will become effective on the date the Insured signs the request, whether or not you are living at the time the request is filed. Any benefits we may have paid prior to receiving this request will meet our contractual obligations to the extent of those payments.

Employer Name:**	Group Number: 38000	
Name of Insured:	Certificate Number:	
Primary Beneficiary Name:	Relationship	Date of Birth
Contingent Beneficiary Name:	Relationship	Date of Birth
SIGNATURES:		
_____	_____	_____
Signature of Insured	Signature of Certificate Owner (if other than Insured)	Date Signed

Beneficiary Designation:

Please give the full legal name of each beneficiary.

- **Primary Beneficiary** means the person or persons who will receive the benefits at the insured's death.
- **Contingent Beneficiary** means the person or persons who will receive the benefits if the primary beneficiary is not living at the time of the insured's death.
- **Will/Trust** - FDL is not in a position to determine the validity of your will or trust beneficiary designation. It is possible that, due to the language of your will or trust, distribution of proceeds would be unclear in the event of your death. Proceeds could be delayed or subjected to the need for a court order. To reassure yourself about the clarity and adequacy of your designation, please obtain an opinion from legal counsel.
- ****Employer** - Texas Insurance Regulations prohibit naming your employer as beneficiary.

Note: Proceeds are paid in equal shares to the named beneficiaries surviving you unless you indicate otherwise.

ILA:

Insurer Copy - Submit with EIB Claim Form