Humana®

Kanawha Insurance Company

Humana Specialty Enrollment
PO Box 14330 Lexington, KY 40512 Fax: 1-866-584-9140

Workplace Voluntary Benefits Beneficiary Form

Insured Information

Insured's Name: _____ Policy Number (One Only)_____

Insured's Social Security Number: _____

Insured's Address: _____

City: _____ State: _____ ZIP+4: _____ Insured's Telephone _____

Policy Owner Information

Policy Owner's Name : _____

Policy Owner's Social Security Number: _____

Policy Owner's Address: _____

City: _____ State: _____ ZIP+4: _____ Policy Owner's Telephone: _____

THE UNDERSIGNED POLICY OWNER HEREBY REVOKES ANY PREVIOUS BENEFICIARY DESIGNATION AND ANY OPTIONAL MODE OF SETTLEMENT WITH RESPECT TO ANY DEATH BENEFIT PROCEEDS PAYABLE AT THE DEATH OF THE INSURED. POLICY OWNER HEREBY MAKES THE BELOW BENEFICIARY DESIGNATION(S). PROCEEDS SHALL BE PAID IN ONE SUM.

IMPORTANT: Check and complete only one of the options below (1-3)

☐ 1. PRIMARY BENEFICIARY(IES) (Designation must add up to 100% - If no percentage is listed, shares will be divided equally)

Full Name_____ Date of Birth_____ Relationship to Insured_____

Address_____ Designation _____%

Full Name_____ Date of Birth_____ Relationship to Insured_____

Address_____ Designation _____%

Full Name_____ Date of Birth_____ Relationship to Insured_____

Address_____ Designation _____%

CONTINGENT BENEFICIARY(IES) (Designation must add up to 100% - If no percentage is listed, shares will be divided equally)

Full Name_____ Date of Birth_____ Relationship to Insured_____

Address_____ Designation _____%

Full Name_____ Date of Birth_____ Relationship to Insured_____

Address_____ Designation _____%

Full Name_____ Date of Birth_____ Relationship to Insured_____

Address_____ Designation _____%

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☐ 2. **TRUSTEE(S) AS PRIMARY BENEFICIARY**

Name of Trust: _____ Date of Trust: _____

Trustee(s):_____

Mailing Address for Trust:_____

Trustee's Phone Number(s): _____

If the Trust is terminated, benefits shall be payable to the Insured's Estate.

☐ 3. **INSURED'S ESTATE - The Insured's Estate**

Either or both of the following may be checked if desired.

☐ 4. POSTPONEMENT CLAUSE

In no case shall any payment be made to any beneficiary designated in this form until thirty (30) days have elapsed following the Insured's death, and in the event of the death of a beneficiary during such period, payment shall be made in the same manner as provided in this form, had the said beneficiary predeceased the Insured. This provision does not apply to a Trustee.

☐ 5. CHILDREN'S CLAUSE

If a child of the Insured predeceases the Insured leaving children who survive the Insured, the share such deceased beneficiary would have received had such beneficiary survived the Insured, shall be paid in equal shares to the surviving children of such deceased beneficiary.

In the event no beneficiary survives the Insured, the benefits will be paid according to the terms of your Policy, which may mean benefits would be paid to the Estate of the Insured.

THIS CHANGE IS SUBJECT TO THE PROVISIONS ON THE FOLLOWING PAGE.

Signature of Policy Owner _____ Date_____

Signature of Witness _____ Date_____

Received and filed with the Insurer:

Authorized Signature_____ Date_____

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PROVISIONS

Unless otherwise provided in the Policy, this beneficiary change shall take effect on the date this form is signed and witnessed, subject to any payments made or action taken by the Insurer before this change is acknowledged by its Home Office.

The Insurer may amend this designation to include any provisions which may be necessary to conform this designation to the Insurer's rules practices and to the terms of the Policy.

The following provisions will apply to this change even though the policy may state otherwise:

The word "Insured" shall mean "Annuitant" where applicable. The word "Contract" is deemed substituted for the word "Policy" where applicable. The word "Owner" means the person or entity that owns and controls this Policy.

Payment of proceeds to any beneficiary is subject to the interest of any assignee.

The term "children of the Insured" shall include any legally adopted child or children of the Insured.

Any payment to a minor beneficiary shall be made to the legally appointed guardian of his or her estate, unless otherwise permitted by law.

In the event a Trustee is named as beneficiary, the Insurer shall not need to inquire into the terms of the trust and shall not need to know its terms. Payment to the named Trustee shall fully discharge all liability of the Insurer to the extent of such payment.
The Policy Owner reserves the right to later change the beneficiary.

LIMITATIONS

This form is not to be used to elect an optional mode of settlement. If a payment in other than one sum is desired, contact the Insurer for help.

This form is not to be used to change the beneficiary in a Family Plan Policy.
If none of the beneficiary designations numbered 1 through 3 provide the settlement wanted by the Policy Owner, contact the Insurer preferably in writing, giving full details so that the appropriate forms can be prepared.

The reference to the Trustee designation on the reverse side of the form was not intended to cover testamentary disposition of proceeds. If a testamentary designation is desired, please write to the Insurer.

If the Policy Owner cannot sign the form other than making his mark (x), contact the Insurer giving full details. The Insurer will indicate the necessary requirements for making the requested change.

INSTRUCTIONS

If a change of beneficiary is desired on more than one policy, complete a separate form for each policy.

Place an "X" in only one of the boxes numbered 1 through 3 to select the desired beneficiary designation. Complete the information requested for that designation. Give the full name (first name, middle initial, and last name) of the desired beneficiary(ies) and the relationship, if any, of each to the Insured and the date of birth. For designation number 2, identify the trust and give the date of the trust agreement.

If a beneficiary is a married woman, furnish her given name, e.g., "Mary S. Doe", not "Mrs. John A. Doe".

A postponement clause (common disaster) and/or a children's clause (per stirpes) may be elected by checking boxes 4 and/or 5.

The Insured or Policy Owner should sign the form exactly as designated in the policy. All signatures should be witnessed. This form is not to be altered.

Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide:

- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call 1-855-448-6982 or, if you use a TTY, call 711.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512-4618

If you need help filing a grievance, call 1-855-448-6982 or, if you use a TTY, call 711.

You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **855-448-6982 (TTY: 711)**.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **855-448-6982 (TTY: 711)**.

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **855-448-6982 (TTY: 711)**。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **855-448-6982 (TTY: 711)**.

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . **855-448-6982 (TTY: 711)** 번으로 전화해 주십시오 .

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **855-448-6982 (TTY: 711)**.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **855-448-6982 (телетайп: 711)**.

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **855-448-6982 (TTY: 711)**.

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **855-448-6982 (ATS : 711)**.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **855-448-6982 (TTY: 711)**.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **855-448-6982 (TTY: 711)**.

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **855-448-6982 (TTY: 711)**.

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **855-448-6982 (TTY: 711)**.

日本語 (Japanese):
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 **855-448-6982** (**TTY：711**) まで、お電話にてご連絡ください。

فارسی (Farsi):
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **855-448-6982 (TTY: 711)** تماس بگیرید.

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **855-448-6982 (TTY: 711)**.

العربية (Arabic):
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **855-448-6982** (رقم هاتف الصم والبكم: **711**).