LEGACY EQ

2011 LIFE INSURANCE BENEFICIARY CHANGE FORM - LTD

Please complete an additional Life Insurance Beneficiary Form if you require additional beneficiaries not already listed on this page. KEEP A COPY FOR YOUR RECORDS.

Employee Last Name	Employee First Name	M Initial	Personnel No: **(Office Use only)**	Employee Social Security No.

In the event of my death, I direct that benefits are payable to my designated beneficiary as indicated below. If more than one person is named as beneficiary, unless otherwise provided herein, benefits payable shall be paid in equal shares to the designated persons who survive me. I understand that if no beneficiary survives me, payment will be made in accordance with the terms of the applicable life insurance plan designated below. I understand that I am revoking any other previous beneficiary forms by completing this form.

(***SIGNATURE AND DATE ARE REQUIRED OR FORM IS NOT VALID FOR PROCESSING)**

Employee Signature: ____ Date Signed: ____

INSURANCE PLANS

A. All Applicable Life Insurance Plans **B.** Basic Life **C.** Voluntary Supplemental Life (If applicable) **D.** VEBA (If applicable)

PRIMARY – (To share equally if more than one named beneficiary):

For Trustee Accounts: List Names, Address, and Phone Number of Executor(s).		**Relationship to Employee**	**Designate %** (Total must equal 100% between listed PRIMARY beneficiaries)	**Life Insurance Plans** (Select alpha list above)	**Full Social Security No.** (Number will NOT be shared to outside sources)	**Date of Birth** Mo.	Day	Yr.
PRIMARY BENEFICIARY:								
ADDRESS:								
PHONE:								
PRIMARY BENEFICIARY:								
ADDRESS:								
PHONE:								
PRIMARY BENEFICIARY:								
ADDRESS:								
PHONE:								

CONTINGENT – If none of the above survives me. (To share equally if more than one named beneficiary):

For Trustee Accounts: List Names, Address, and Phone Number of Executor(s).		**Relationship to Employee**	**Designate %** (Total must equal 100% between listed CONTINGENT beneficiaries)	**Life Insurance Plans** (Select alpha list above)	**Full Social Security No.** (Number will NOT be shared to outside sources)	**Date of Birth** Mo.	Day	Yr.
CONTINGENT BENEFICIARY:								
ADDRESS:								
PHONE:								
CONTINGENT BENEFICIARY:								
ADDRESS:								
PHONE:								
CONTINGENT BENEFICIARY:								
ADDRESS:								
PHONE:								

Please return original to the CenturyLink Benefits Administration, 5454 W. 110th Street, Mail Stop: KSOPKR0301-A, Overland Park, KS 66211 Or fax to 1-913-397-3767. For questions, please contact Benefits Administration at 1-888-722-4372, option 1, option 6.