



DESIGNATION OF BENEFICIARY

District of Columbia Employees Group Life Insurance

WARNING
Read Instructions on back of duplicate before filling in this form

INFORMATION CONCERNING THE INSURED:

Name (Last, First, Middle)	Date of Birth (Month, Day, Year)	Social Security Number
----------------------------	----------------------------------	------------------------

Place an "X" in the appropriate box below:

<input type="checkbox"/> An Employee	<input type="checkbox"/> Retired or applicant for retirement	<input type="checkbox"/> Receiving Disability Compensation benefits or an applicant for Disability Compensation benefits	If you are retired or receiving Disability Compensation, give your claim number.
--------------------------------------	--	--	--

Department or agency in which presently employed (If retired or on Disability Compensation, former department or agency):

Department or Agency	Bureau	Division
----------------------	--------	----------

I, the individual identified above, canceling any and all previous Designations of Beneficiary under the District of Columbia Employees Group Life Insurance Program heretofore made by me, do now designate the beneficiary or beneficiaries named below to receive any amount of LIFE INSURANCE and ACCIDENTAL DEATH INSURANCE due and payable at my death. I understand that this Designation of Beneficiary will remain in full force and

effect, with respect to any amount payable, unless or until canceled by me in writing, or until such time as it is automatically canceled (see regulation "f" on reverse side of duplicate copy). If this designation form is determined invalid for any reason, the next prior valid designation form will be given full force and effect. If no such prior form exists, the proceeds will be distributed according to the Order of Precedence.

INFORMATION CONCERNING THE BENEFICIARY OR BENEFICIARIES (See Examples of Designations):

Type or Print First Name, Middle Initial, and Last Name of Each Beneficiary	Type or Print Address (Including ZIP Code) of Each Beneficiary	Relationship	Share to Be Paid to Each Beneficiary		
<table border="1"> <tr> <td>Social Security No. (if available)</td> <td>Birthdate (if available)</td> </tr> </table>	Social Security No. (if available)	Birthdate (if available)			
Social Security No. (if available)	Birthdate (if available)				
<table border="1"> <tr> <td>Social Security No. (if available)</td> <td>Birthdate (if available)</td> </tr> </table>	Social Security No. (if available)	Birthdate (if available)			
Social Security No. (if available)	Birthdate (if available)				
<table border="1"> <tr> <td>Social Security No. (if available)</td> <td>Birthdate (if available)</td> </tr> </table>	Social Security No. (if available)	Birthdate (if available)			
Social Security No. (if available)	Birthdate (if available)				

For each type of insurance (Basic Life, Option A—Standard, and Option B—Additional): (1) I hereby direct, unless otherwise indicated above, that if more than one beneficiary is named, the share of any beneficiary who may predecease me or become disqualified for any reason from receiving a share of the benefits shall be distributed equally among the surviving beneficiaries, or entirely to the

survivor; (2) I understand that this Designation of Beneficiary shall be void if none of the designated beneficiaries is living at the time of my death.

I hereby specifically reserve the right to cancel or change this designation of beneficiary at any time without knowledge or consent of the beneficiary.

PRINT OR TYPE NAME AND ADDRESS (Including ZIP Code) OF INSURED

Please check:

- I have signed this form in the presence of the **two** witnesses who have signed below.
- Neither witness is named as a beneficiary.
- If I designated shares to be paid to more than one beneficiary, the shares add up to 100%. (Dollar amounts are not acceptable.)

Date of Execution (Month, Day, Year)

--

Signature of Insured

WITNESSES TO SIGNATURE (A witness is ineligible to receive payment as a beneficiary):

Signature of Witness	Number and Street	City, State and ZIP Code
Signature of Witness	Number and Street	City, State and ZIP Code

Receiving Agency	Date of Receipt	Agency Signature	Title
------------------	-----------------	------------------	-------

SEE REVERSE SIDE OF DUPLICATE COPY FOR INSTRUCTIONS ON WHERE TO FILE THESE FORMS.