Group Long-Term Care Beneficiary Designation for Return of Premium Proceeds

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza

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Instructions for Completing the Beneficiary Form

The Beneficiary Form is attached. Examples of wording that can be used to designate a beneficiary on this Form are set forth below.

Type of Beneficiary	Sample Wording
1. Single Named Person	"Jane Doe, wife"
2. Two or more named persons in equal shares	"John Doe, father, and Mary Doe, mother, in equal shares"
3. Two or more named persons in unequal shares	"40 percent to John Doe, father, and 60 percent to Mary Doe, mother" – **[do not use dollar amounts]**
4. Unnamed children of a specified marriage (excluding children by a previous marriage, foster children and stepchildren)	"Children of the marriage of the insured and Jane Doe"
5. Trustee under Last Will and Testament of Insured	"Trustee, or successor in Trust, named in the Last Will and Testament of the Insured; provided, however, that if no Trustee is appointed within one year of the Insured's death, payment shall be made to the Insured's estate"
6. Other Trust Arrangements	"Professional Trust Company, Trustee, or its successor in Trust, under Trust Agreement dated Jan. 1, 1982"

Instructions for Signing Beneficiary Form

Who Must Sign: The Beneficiary Form must be signed by the person or persons who, under the terms of the policy, have the right to designate the beneficiary.

How to Sign: Your request cannot be processed without the correct signature(s), date and applicable documentation. If signed by a **holder of power of attorney, such party** must provide a copy of the power of attorney and include, following his or her signature, the words "Attorney-in-fact for (insured's name)."

If signed with an "X" mark or in foreign characters, the signature must be witnessed by two witnesses and the address of each witness must be given.

Insured Name ____ Social Security Number ____

Insured Address ____ Telephone Number ____

Employer/Association Group Name: American Foreign Service Protective Association

Policy Number: GMLC-2Y67

IMPORTANT!

1. Proceeds payable must be expressed as percentages rather than dollar amounts.
2. Please use full given names. Examples: "Mary E. Doe" rather than "Mrs. John E. Doe."
3. Forms cannot be accepted which contain corrections or erasures.
4. If more space is needed for additional beneficiaries, please attach a separate sheet of paper or copy of this form.
5. Complete, sign and return this form

Mail completed form to: American Foreign Service Protective Association
1620 L Street NW, Suite 800
Washington, DC 20036

Fax to: ATTN: AIP Dept
202-775-9082

Primary Beneficiary(ies)

Name ____ Date of Birth ____
Address ____ Telephone ____
Social Security Number ____ Relationship _ Benefit Percent ____

Name ____ Date of Birth ____
Address ____ Telephone ____
Social Security Number ____ Relationship _ Benefit Percent ____

Contingent Beneficiary(ies)

Name ____ Date of Birth ____
Address ____ Telephone ____
Social Security Number ____ Relationship _ Benefit Percent ____

Name ____ Date of Birth ____
Address ____ Telephone ____
Social Security Number ____ Relationship _ Benefit Percent ____

Please see next page

Unless otherwise shown above: (a) payment will be shared equally by all Primary Beneficiaries who survive the Insured; if none, by all Contingent Beneficiaries who survive the Insured; (b) the right to change the beneficiary is reserved unless otherwise stated; (c) the word "child" or "children" shall include legally adopted children.

The company reserves the right to declare this form void and of no effect if it is incomplete or completed in an unsatisfactory manner.

*X*____

Signature of Insured **Date**