Instructions for Beneficiary Designation Change Form (SF 4400-VTL)

ON ROLL EMPLOYEES

IMPORTANT: Beneficiary changes will NOT go into effect until signed and dated by the employee with the original mailed to the address for SHPS at the bottom of the form.

1. Complete the form with your name, social security number, beneficiary (ies) and check the appropriate options.

2. This form applies ONLY to the Voluntary Term Life Insurance. To apply for an increase you will also need a Statement of Insurability form, which can be obtained from Benefits at 844-4237 or call SHPS at 1 800-843-7724 and leave a message.

3. You may have other insurance coverages (e.g. Primary Group Term Life Insurance) and/or VGA (Voluntary Group Accident Insurance please check the internal web under "Your Benefits Summary") for a list of your current coverages.

4. Be sure to make a copy of the beneficiary change forms (and don't forget to file a copy of this form with your other legal documents) before you return the original to SHPS.

RETIREES

1. Retirees can cancel their VTL by sending this completed form to the Customer Service Center, MS-1463.

2. Complete the form with your name, social security number, beneficiary(ies) and check the appropriate options.

3. Retirees are not eligible to increase coverage.

4. This form applies ONLY to the Voluntary Term Life Insurance.

5. Coverage for VTL for Retirees terminates at age 65 for those who retired prior to January 1, 2007. If you retire after 12/31/2006, your existing coverage level (multiple of rounded base pay) can be retained to age 65. You are also eligible to carry up to two times annual base pay in VTL benefits past age 65, if: (1) current coverage equals or exceeds that 2 x pay, and, (2) you continue to pay applicable monthly premiums.

6. Retirees may contact Benefits Customer Service at 845-2363 to check other insurance coverage's (e.g., Basic Supplemental Group Term Life Insurance **OR** Primary Group Term Life Insurance).

SF 4400-VTL (12-2007) Supersedes (10-2006) Issue

HR Proprietary

VOLUNTARY TERM LIFE INSURANCE PROGRAM FOR EMPLOYEES OF SANDIA CORPORATION

Please contact the Voluntary Term Life Administration Unit at 1-800-843-7724 with questions regarding this form.

A. EMPLOYEE INFORMATION	**Employee Social Security No.**	**POLICY NO. 96020**

EMPLOYEE NAME LAST FIRST MIDDLE

STREET ADDRESS APT. DATE HIRED

CITY STATE ZIP WORK PHONE ( ) HOME PHONE ( )

B. ACTION

(1) ☐ Enroll (Complete Sections A, B, C, D, & E)

(2) ☐ Change Coverage Option (Complete Sections A, B, C, & E)

(3) ☐ Cancel (Complete Sections A, B, & E)

(4) ☐ Name Change (Complete Sections A, B, & E)

(5) ☐ Beneficiary Change (Complete Sections A, B, D, & E)

(6) ☐ Decline Coverage (Waiver) (Complete Sections A, B, & F)

C. COVERAGE OPTION (Check One)

☐ **1 Time Annual Base Pay*** ☐ **2 Time Annual Base Pay*** ☐ **3 Time Annual Base Pay*** ☐ **4 Time Annual Base Pay*** ☐ **5 Time Annual Base Pay*** ☐ **6 Time Annual Base Pay***

***rounded to the next higher one thousand dollars**

The Voluntary Term Life Insurance Program booklet contains specific details regarding the Program provisions, including the effective date of changes in coverage.

I hereby request to be insured under the Voluntary Term Life Insurance Program as indicated above. I authorize Sandia to deduct the monthly premium from my pay or benefits.

I understand that if my requested level of coverage is more than $1,250,000 at initial enrollment, evidence of my insurability will be required. I also understand that I may change my coverage option at any time. However, in order to become insured for a new option, which increases coverage, evidence of good health, satisfactory to Prudential, must be provided.

D. BENEFICIARY DESIGNATIONS

In accordance with the conditions of the Group Policy issued to Sandia Corporation for the Voluntary Term Life Insurance Program by Prudential Life Insurance Company of America, I hereby revoke any previous designations of primary beneficiary(ies) and designate as primary beneficiary(ies) and contingent beneficiary(ies) in the event of my death, the following:

Name (Legal Name)	Relationship	Date of Birth	Address	Share

In the event all primary beneficiaries predecease me, I designate as contingent beneficiaries:

CONTINGENT BENEFICIARY DESIGNATION

If additional space is required, please continue on separate sheet, sign, date and attach to this from.

E.

_____ _____

Date **Employee's Full Signature**

F. WAIVER OF VOLUNTARY TERM LIFE INSURANCE COVERAGE

I have received the booklet explaining the Voluntary Term Life Insurance Program. I elect not to participate at this time. I understand that I will be required to furnish evidence of good health should I wish to enroll at a later date.

_____ _____

Date **Employee's Full Signature**

DO NOT ATTEMPT TO ERASE OR MAKE ANY CORRECTION; USE A NEW FORM (If you have any questions call your local Benefits office or the Voluntary Term Life Administration Unit at 1-800-843-7724.)

SHPS
Life Insurance Administration Unit
PO Box 32800
Louisville, KY 40232-2800