BENEFICIARY DESIGNATION FORM

CIGNA Group Insurance
Life • Accident • Disability

Philadelphia, Pennsylvania

Name of Policyholder: **American Academy of Ophthalmology**
Under Group Policy No. **ABL 63 13 15**

Revoking any previous beneficiary named under the Certificate, referred to above, I hereby designate the following:

If the insurance matures by death the proceeds then payable shall, subject to any facility of payment provision which may apply, be payable to:

Beneficiary Name: _____

Relationship to Insured: _____

Beneficiary Address: _____

Name of Policyholder: _____

Member SS#: _____

Date: _____ Signature of Insured or Assignee if Applicable_____

FAX TO:
415-561-8526
Office of the Executive Vice Presidents
Administrative Coordinator – Board of Trustees