DESIGNATION OF ALTERNATE BENEFICIARY

EXPANDED DEPENDENT LIFE AND AD&D INSURANCE

UBEN 119 (R7/12) University of California Human Resources

USING THIS FORM

Use this form only to name or change beneficiaries for family members enrolled in the Expanded Dependent Life and Accidental Death and Dismemberment (AD&D) insurance plans. This is not an enrollment form. You may enroll in the plans for which you are eligible either electronically or by completing a paper form.

You are automatically the beneficiary for family members who are covered under your Expanded Dependent Life and/or AD&D insurance plans. However, you may name someone else to receive benefits if a covered family member dies.

Designation of a beneficiary may have significant tax and inheritance consequences for the beneficiary. Consult your attorney or tax advisor for more information.

COMPLETING THIS FORM

If you have questions or need help, contact your local Benefits Office.

General Instructions Type this form or complete it in ink. This is a legal document, so erasures or other corrections will not be accepted.

Your beneficiary may be any person or persons you want to name. "Person" includes any entity capable of taking and holding property.

Enter the beneficiary's full name in the space provided. For example, enter "Mary Lou Smith" rather than "Mrs. John Smith." If the beneficiary's first name consists of initials only, enter "IO" (meaning Initials Only) in parentheses following the person's name. **Be sure to include the beneficiary's birthdate.**

You may name as many beneficiaries as you like. If you name more than one person, the benefit will be paid in equal shares unless you specify the share (%) each is to receive. If you specify shares, they must be whole percentages (for example, 50% rather than 50.5%), and total shares must add up to 100%.

You may name your estate as the beneficiary for these plans and then provide for payment in a will. You may also name a trust as the beneficiary. If you do so, you must provide the name and date of the trust and the name and address of the trustee.

Beneficiary designations are contractual in nature and generally avoid probate **unless** the estate is the beneficiary. Consult your attorney for more information and advice.

Expanded Dependent Life Insurance You may name an alternate beneficiary only for your legal spouse or eligible domestic partner. You remain the beneficiary for any covered children.

AD&D Insurance You may name separate beneficiaries for each covered family member. To do so, name each family member on the form and give the beneficiary's name and address for each one. If you want the same beneficiary(ies) to receive benefits for all family members, do not complete the "Covered Family Member" line.

CHANGING YOUR BENEFICIARY

You may change your beneficiary at any time either online or by submitting a new form. Once UC Human Resources accepts a new form, all previous designations are invalid.

Changes in your family situation—for example, marriage or divorce—do not automatically alter or revoke your previous beneficiary designations. **A beneficiary designation remains valid until you submit a new one.** You should review your beneficiary designations for your retirement and insurance plans any time there is a change in your family situation.

A will does not supersede a beneficiary designation.

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EXPANDED DEPENDENT LIFE AND AD&D INSURANCE

UBEN 119 (R7/12) University of California Human Resources

Send completed form to:
UC HR—Records Management
P.O. Box 24570
Oakland, CA 94623-1570

PERSONAL INFORMATION (PLEASE PRINT)

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NO	EMPLOYEE ID NO	BIRTHDATE (MO/DY/YR)
MAILING ADDRESS (Number, Street, City, State, ZIP)		HOME PHONE ( )	CAMPUS/LAB LOCATION

EXPANDED DEPENDENT LIFE (PLEASE PRINT)

If my legal spouse/eligible domestic partner dies, I authorize benefits to be paid to the person(s) named below. (If percentages are specified, they must add up to 100%.)

BENEFICIARY'S NAME (Last, Middle Initial, First)	SHARE %	BIRTHDATE MO DY YR	RELATIONSHIP TO EMPLOYEE	ADDRESS (Number, Street, City, State, ZIP)

ACCIDENTAL DEATH AND DISMEMBERMENT (PLEASE PRINT)

If a covered family member dies, I authorize benefits to be paid to the person(s) named below. (If percentages are specified, they must add up to 100%.)

If you need more space, check here ☐ and complete another form. **If you want to name the same beneficiary for all family members, do not fill in the "Covered Family Member" line.**

COVERED FAMILY MEMBER'S NAME		BIRTHDATE MO DY YR	RELATIONSHIP TO EMPLOYEE	
BENEFICIARY'S NAME (Last, Middle Initial, First)	SHARE %	BIRTHDATE MO DY YR	RELATIONSHIP TO EMPLOYEE	ADDRESS (Number, Street, City, State, ZIP)
COVERED FAMILY MEMBER'S NAME		BIRTHDATE MO DY YR	RELATIONSHIP TO EMPLOYEE	
BENEFICIARY'S NAME (Last, Middle Initial, First)	SHARE %	BIRTHDATE MO DY YR	RELATIONSHIP TO EMPLOYEE	ADDRESS (Number, Street, City, State, ZIP)

REQUIRED SIGNATURE

I understand that:

- If I have named more than one beneficiary, benefits will be paid in equal shares unless I specify otherwise.
- If the beneficiary(ies) named above are deceased, benefits will be paid to me.
- This designation supersedes any previous designation.
- The University will require proof of death and identity before making payment.

SIGNATURE	DATE	E-MAIL

ORIGINAL: UC HR
EMPLOYEE: PLEASE PHOTOCOPY FOR YOUR FILES

SEE PAGE 3 FOR PRIVACY NOTIFICATIONS

PRIVACY NOTIFICATIONS

STATE

The State of California Information Practices Act of 1977 (effective July 1, 1978) requires the University to provide the following information to individuals who are asked to supply information about themselves.

The principal purpose for requesting information on this form, including your Social Security number, is to verify your identity, and/or for benefits administration, and/or for federal and state income tax reporting. University policy and state and federal statutes authorize the maintenance of this information.

Furnishing all information requested on this form is mandatory. Failure to provide such information will delay or may even prevent completion of the action for which the form is being filled out. Information furnished on this form may be transmitted to the federal and state governments when required by law.

Individuals have the right to review their own records in accordance with University personnel policy and collective bargaining agreements. Information on applicable policies and agreements can be obtained from campus or Office of the President Staff and Academic Personnel Offices.

The official responsible for maintaining the information contained on this form is the Vice President—University of California Human Resources, 1111 Franklin Street, Oakland, CA 94607-5200.

FEDERAL

Pursuant to the Federal Privacy Act of 1974, you are hereby notified that disclosure of your Social Security number is mandatory. The University's record keeping system was established prior to January 1, 1975 under the authority of The Regents of the University of California under Article 1X, Section 9 of the California Constitution. The principal uses of your Social Security number shall be for state tax and federal income tax (under Internal Revenue Code sections 6011.6051 and 6059) reporting, and/or for benefits administration, and/or to verify your identity.