Rapid Assistance to Community Emergencies, Inc.

P.O. Box 334, Delaware, Ohio 43015

BENEFICIARY DESIGNATION FOR ACCIDENT & SICKNESS POLICY FORM – VFIS ®

Name of Organization: **RAPID ASSISTANCE TO COMMUNITY EMERGENCIES, INC.**
Address of Organization: **P.O. Box 334, Delaware, OH 43015**

Member's/Employee's Name: ______________________________ **State:** OHIO

Member's/Employee's Date of Birth: _____/_____/____ **Date Member Joined/Hired:** _____/_____/_____

I hereby designate the following beneficiary (ies) with respect to amounts payable as indemnity for loss of life un the referenced Accident & Sickness Policy and hereby revoke any designation thereunder heretofore made by me. I direct that any amounts payable under said policy to my beneficiary (ies) named below paid to those of Primary Beneficiary who survive me, otherwise to those surviving in Contingent Beneficiary, in proportion to the percentages listed.

Primary Beneficiary:
(Person (s) who will receive the insurance proceeds.)

Name: ____________________________ **Relationship:** _______________ **DOB:** ___/___/___ **Share** ______%

Name: ____________________________ **Relationship:** _______________ **DOB:** ___/___/___ **Share** ______%

Name: ____________________________ **Relationship:** _______________ **DOB:** ___/___/___ **Share** ______%

Name: ____________________________ **Relationship:** _______________ **DOB:** ___/___/___ **Share** ______%

Contingent Beneficiary:
(Person (s) who will receive the insurance proceeds if the Primary Beneficiary is not alive at the time of your death.)

Name: ____________________________ **Relationship:** _______________ **DOB:** ___/___/___ **Share** ______%

Name: ____________________________ **Relationship:** _______________ **DOB:** ___/___/___ **Share** ______%

Name: ____________________________ **Relationship:** _______________ **DOB:** ___/___/___ **Share** ______%

Name: ____________________________ **Relationship:** _______________ **DOB:** ___/___/___ **Share** ______%

If none of the above-named beneficiaries are living at the time of my death, I direct that payment be made in accordance with the terms of this policy. I reserve the right to revoke or change this designation.

Signature: _________________________________ ***Date:*** ___/___/___