UNIMED
GROUP HEALTH PLAN

H.O. 39 Boissiere Village,
Maraval, Trinidad & Tobago.
+1 868-607-1274

# CHANGE OF BENEFICIARY

Please complete in **BLOCK LETTERS**. Incomplete forms will not be processed.

## A. Member Information

Last Name | First Name | Middle Name

Employer :

Unimed ID Number :

Valid Government Identification Number : *(Please provide a copy of **one(1)** form of identification)*

☐ National ID ☐ Driver's Permit ☐ Passport

## B. Beneficiary Information

*I hereby designate the below as a beneficiary under the Unimed Plan and revoke the appointment of any existing beneficiary. I reserve the right, without the consent of any listed beneficiary, to make further changes subject to any statutory restrictions.*

| New Beneficiary First Name | Last Name | Relationship | Date of Birth DD-MM-YYYY | Contact |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| Member Signature | | | | | |
|---|---|---|---|---|---|
| Member: | | Date: | | Signature: | |
| Witness: | | Date: | | Signature: | |

**Note**: If more than one beneficiary is named, payment shall be made in equal shares to the beneficiaries who survive the member, if no beneficiary survives the member, payment shall be made to such persons in such order of preferences as constitute the legal laws of the beneficiaries. The right to further change the beneficiary is reserved unto the member without the consent on the beneficiary. It is warranted that this is not now assigned.

In the case of a child, consent is not possible until the child attains age eighteen (18) at which time the child is required to sign.

*This is to certify that a copy of the above Request is filed on the record with M & M Insurance Broking Services Ltd.*

**Dates at** | **this** | **day of**

*Authorized Signature*