GROUP LIFE BENEFICIARY CHANGE FORM

SENTRY LIFE INSURANCE COMPANY OF NEW YORK

ACCOUNT NUMBER	NAME OF BUSINESS

NAME OF EMPLOYEE (Please Print)

PRIMARY BENEFICIARY(IES)

Primary beneficiary's Name and Address	Social Security Number	Relationship to You	Date of Birth	Percentage: Must equal 100%
Name: Address: Phone Number:				
Name: Address: Phone Number:				
Name: Address: Phone Number:				

Note: If you designate two or more beneficiaries, they will share equally in the benefit unless you indicate otherwise. If the beneficiary is a trust, complete the applicable fields with the trust information and include the date of the trust as the date of birth entry.

CONTINGENT BENEFICIARY(IES) (Contingent beneficiaries will only receive benefit if there are no surviving primary beneficiaries.)

Contingent beneficiary's Name and Address	Social Security Number	Relationship to You	Date of Birth	Percentage: Must equal 100%
Name: Address: Phone Number:				
Name: Address: Phone Number:				
Name: Address: Phone Number:				

Note: If you designate two or more beneficiaries, they will share equally in the benefit unless you indicate otherwise. If the beneficiary is a trust, complete the applicable fields with the trust information and include the date of the trust as the date of birth entry.

I hereby make the Beneficiary changes indicated above and revoke any current designations.

SIGNATURE OF EMPLOYEE	DATE OF SIGNATURE

Send the completed Group Life Beneficiary Change Form to the address below. Your beneficiary change will be recorded and a copy of this form will be returned to you to be attached to your certificate of insurance.

Office Use Only

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Initial/Date

Return to:

Servicing Office
2225 Minnesota Ave.
P.O. Box 8024
Stevens Point, WI 54481-8024