GTL | GUARANTEE TRUST LIFE

Mail To:
409 W Vickery Blvd
Fort Worth, TX 76104
Or Email: info@ubamembers.com
For Customer Service, please call: 866-438-4274

ASSOCIATION DEATH BENEFICIARY DESIGNATION FORM

Healthy America Association (HAA)

Group/Association Name or Policy Number | Member ID No.

Name of Insured Member | Alternate Name | Insured Member Date of Birth (/ /) | ☐ Male ☐ Female

Address (Street) | (City) | (State) | (Zip Code)

( )

Phone Number | Email (Please provide for faster service)

BENEFICIARY INFORMATION

% | Name of Beneficiary | Date of Birth | Relationship

Address (Street) | (City) | (State) | (Zip Code)

% | Name of Beneficiary | Date of Birth | Relationship

Address (Street) | (City) | (State) | (Zip Code)

% | Name of Beneficiary | Date of Birth | Relationship

Address (Street) | (City) | (State) | (Zip Code)

% | Name of Beneficiary | Date of Birth | Relationship

Address (Street) | (City) | (State) | (Zip Code)

I designate the person(s) on this form as my beneficiary(ies) to receive any payment from the association policy or policy number shown above. I fully understand that this designation of beneficiary(ies) applies to the full Accidental Death Benefit Amount that is in force.

Insured Member's Signature | Date (/ /)