## Beneficiary Change Form

This form is only for persons who:

- ▶ are currently enrolled in the Federal Long Term Care Insurance Program (FLTCIP) 3.0
- ▶ wish to update existing or designate new beneficiary(ies) for their FLTCIP plan

If you have questions regarding beneficiary information, call us at **1-800-LTC-FEDS** (1-800-582-3337) **TTY** 1-800-843-3557 or visit **LTCFEDS.com/login** to access your account.

Personal information
☐ Mr. ☐ Mrs. ☐ Ms.
First name M.I. Last name
Address line 1
Address line 2
City State/Territory
Country Zip/Foreign postal code
Gender Home phone  Male Female
Date of birth  Mobile phone  Month Day Year
Email
Social Security number*  U

### Beneficiary Change Form (continued)

Your Federal Long Term Care Insurance Program (FLTCIP) 3.0 coverage includes a refund of premium death benefit. The amount that may be available for this benefit is variable. If your coverage is in force on your date of death, any available amount will be paid to your designated beneficiary, your estate, or an alternative payee, as applicable. Use this form to update existing or designate new beneficiary (ies) for your FLTCIP plan.

☐ Check this box if you would like to designate 100% of this benefit to be paid only to your estate.

If you checked the box above, you may skip the remainder of the beneficiary section below and sign and date the form on page 4 and mail back to: Long Term Care Partners, LLC, P.O. Box 797, Greenland, NH 03840-0797.

or

If you would like to designate or update specific beneficiaries, continue below. If any of the required information is incomplete, no changes will be made to your existing beneficiary designations on file.

Please provide the following:

- ▶ all demographic information for each beneficiary listed
- ▶ an allocation percentage of at least 1% and no greater than 100% if more than one beneficiary is designated

Note: The total sum of all beneficiaries' allocation percentages must equal 100%. If any beneficiary predeceases you, unless you select another beneficiary, any amount payable on your death will be paid to the remaining beneficiaries.

If the above criteria is not met, or the provided information is not complete, no changes will be made to your existing beneficiary designations on file. If the information on this form meets the above criteria, it will replace any and all beneficiary information that we have on file. To complete your beneficiary information, please submit this form with the required information or visit LTCFEDS.com/login to access your account.

To designate specific beneficiaries, please fill out the form below.

#### **Beneficiary 1**

Please select the type of beneficiary you wish to designate for beneficiary 1 and provide the required information below.

☐ Individual ☐ Trust or organization ☐ Your estate\*

\*For estate, please provide only the allocation percentage in the designated box below.

For individuals, provide:	For trusts or organizations, provide:	Allocation percentage
First name  M.I. Last name  Date of birth/	Trust or organization name  Tax ID number	%
Social Security number or national ID	Contact name or trustee	
Relationship to applicant		
Address		
City	State/Territory	
Country	Zip/Foreign postal code	
	Zip/i oreigii postai code	
Email		
Phone Home Mobile Office		

## Beneficiary Change Form (continued)

(mm/dd/yy)

#### **Beneficiary 2** Please select the type of beneficiary you wish to designate for beneficiary 2 and provide the required information below. ☐ Individual ☐ Trust or organization ☐ Your estate\* \*For estate, please provide only the allocation percentage in the designated box below. For individuals, provide: For trusts or organizations, provide: Allocation percentage First name Trust or organization name M.I. Last name

Tax ID number

Contact name or trustee

State/Territory

Zip/Foreign postal code

%

### **Beneficiary 3**

Address

Country

Email

City

Date of birth

Relationship to applicant

Social Security number or national ID

Phone Home Mobile Office

Please select the type of beneficiary you wish to designate for beneficiary 3 and provide the required information below.

☐ Individual ☐ Trust or organization ☐ Your estate\*

\*For estate, please provide only the allocation percentage in the designated box below.

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For individuals, provide:	For trusts or organizations, provide:	Allocation percentage
First name  M.I. Last name  Date of birth/	Trust or organization name  Tax ID number	%
Social Security number or national ID  Relationship to applicant	Contact name or trustee	
Relationship to applicant		
Address		
City	State/Territory	
Country	Zip/Foreign postal code	
Email		
Phone Home Mobile Office		

If you have any questions, please call 1-800-LTC-FEDS (1-800-582-3337) TTY 1-800-843-3557 for assistance.

# Beneficiary Change Form (continued)

	Trust or organization name  M.I. Last name Date of birth / (mm/dd/yy)  Social Security number or national ID  Relationship to applicant  City State/Territory  Country Zip/Foreign postal code  Email Phone Home Mobile Office  Note: The total sum of all beneficiaries' allocation percentages must equal 100%.	M.I. Last name Date of birth // (mm/dd/yy)  Social Security number or national ID  Relationship to applicant  City  State/Territory  Zip/Foreign postal code  Email  Phone   Home   Mobile   Office  Note: The total sum of all beneficiaries' allocation percentages must equal 100%.  Total percentage (The total sum must equal 100%.)  Maintaining accurate beneficiary information allows us to help expedite any available payment under the refun of premium death benefit to your designated beneficiary(ies). If the form criteria is not met, or the provided information on this form meets the required criteria, it will replace any and all beneficiary information that we have on file.	*For estate, please provide only the allocation For individuals, provide:	For trusts or or								Α	lloc	atio	n p	erce	ntag
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Please return the completed form to Long Term Care Partners, LLC, P.O. Box 797, Greenland, NH 03840-0797.



The **Federal** Long Term Care Insurance Program™

The Federal Long Term Care Insurance Program is sponsored by the U.S. Office of Personnel Management, insured by John Hancock Life & Health Insurance Company, and administered by Long Term Care Partners, LLC.



