GROUP HEALTH PLAN
M&M INSURANCE SERVICES LIMITED

CHANGE OF BENEFICIARY

MEMBER'S NAME:	(Last Name)		(First Name)
DATE OF BIRTH:		NIS #:	
ADDRESS:			

With effect from , I hereby designate the following beneficiary with respect to indemnity for loss of life, revoking any previous beneficiary designation(s) with respect to my Death Benefit under the Unimed Group Health Plan.

Name of New Beneficiary (Last Name) (First Name)	**Date of Birth** dd/mm/yy	**Relationship**

Signed:

Date:

	Date	Initial
Received:		
Processed:		

Form Ref: DBC-EMP-06/01

IMPORTANT INFORMATION

Please complete and sign the form and return it to:

- The Plan Administrator
  Unimed Group Health Plan
  M&M Insurance Services Limited
  39 Boissiere Village
  MARAVAL

2. This form must be signed by the member. The change of beneficiary cannot be processed without the consent of the member as evidenced by the member's signature.

3. The change becomes effective from the date indicated. If no date is shown, the change will be effective from the date of signature on the form.