APPOINTMENT OF NEW BENEFICIARY

Please complete this form and forward to Protective Life Insurance Company
A recorded copy will be returned for filing with your Certificate of Insurance

Name of Insured: _____ **Critical Illness Plan**
Policy 1127GH-CI
Certificate #_____

Name of Group: AMERICAN DENTAL ASSOCIATION **ADA #** _____

If the insured is eligible for unpaid benefits at the time of death, benefits will be payable to your named beneficiary.

If more than one beneficiary is listed, please indicate the percentage to be paid to each beneficiary. If no percentage is indicated, the benefit will be paid equally among the beneficiaries.

I hereby revoke any previous appointment and appoint the following as beneficiary of any moneys payable upon death.

DESIGNATION OF BENEFICIARY
PRIMARY (to include FULL NAME AND RELATIONSHIP for each entity)

Full Name	Relationship	Percentage

CONTINGENT
(if Primary Beneficiary predeceases Insured OR dies after Insured but before proceeds exhausted).

Full Name	Relationship	Percentage

_____ _____

Signature of Insured **Date**