BENEFICIARY CARD

Please fill out and mail this BENEFICIARY DESIGNATION NOTIFICATION in a stamped envelope to:

CIGNA HealthCare
P.O. Box 55270
Phoenix, AZ 85078-5270

1. YOUR NAME ____

2. SOCIAL SECURITY # ____ ____ ____ - ____ ____ - ____ ____ ____ ____

3. YOUR ADDRESS

ADDRESS____

CITY ____

STATE______________________________ZIP ____________________

4. BENEFICIARY____
   Name of person who will receive benefit in the case of your accidental death.

5. YOUR BENEFICIARY'S ADDRESS

ADDRESS____

CITY ____

STATE______________________________ZIP ____________________

5. AUTHORIZATION
   By signing below I confirm that I have named my beneficiary

____

SIGNATURE DATE