Aetna Life Insurance Company
Designation of Beneficiary

Please keep a copy for your records.

Group Policyholder Name	Group Policy Number
Hawaii Employer-Union Health Benefits Trust Fund	881930
Employee/Retiree Name and Address	Employee/Retiree Social Security Number

Subject to the terms of the above numbered Group Policy(ies), I request that any sum becoming payable by reason of my death be payable to the following beneficiary(ies). It is my understanding that this designation shall operate so as to revoke all designations of beneficiary and all elections of optional methods of settlement previously made by me under said Policy(ies). If this Designation of Beneficiary refers only to a Group Life Insurance Policy and if I am also insured for Supplemental and/or Group Accidental Death coverage, this designation shall apply to those coverages. This Designation of Beneficiary is subject to all "Conditions" shown on the back of this form.

Employee/Retiree Signature		Date	
Beneficiary Name and Address	[X] Primary Beneficiary*		
Relationship	Social Security Number	Date of Birth (MM/DDIYYYY)	Percentage
Beneficiary Name and Address	(Please check one) [ ] Primary Beneficiary* or [ ] Contingent Beneficiary**		
Relationship	Social Security Number	Date of Birth (MM/DDIYYYY)	Percentage
Beneficiary Name and Address	(Please check one) [ ] Primary Beneficiary* or [ ] Contingent Beneficiary**		
Relationship	Social Security Number	Date of Birth (MM/DDNYYY)	Percentage
Beneficiary Name and Address	(Please check one) [ ] Primary Beneficiary* or [ ] Contingent Beneficiary**		
Relationship	Social Security Number	Date of Birth (MM/DDIYYYY)	Percentage

*If more than one primary beneficiary is named, the primary beneficiaries shall share equally unless otherwise indicated above.
"Contingent Beneficiary(ies) will only receive proceeds if all Primary Beneficiaries have predeceased the Insured. If you are naming more than one Contingent Beneficiary at I 00% each, please indicate 1st contingent, 2nd contingent, 3rd contingent, etc. in the order of precedence.

SPOUSAL CONSENT FOR COMMUNITY PROPERTY STATES ONLY*** - See Conditions on the back of this form.
*** Please note that an employee/retiree is under no obligation to complete the Spousal Consent section of this form.

I am aware that my spouse, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse Signature ______________________________ Date ____________________