

<b>HARTFORD LIFE &amp; ACCIDENT</b>		<b>VOLUNTARY ACCIDENTAL DEATH &amp; DISMEMBERMENT BENEFICIARY CHANGE FORM</b>	
<b>Policyholder: MEDICAL COLLEGE OF GEORGIA</b>		<b>Policy No. 20-ADD-S07830</b>	
Insured's Name		Date of Birth	
Beneficiary	Relationship	Percentage	
<input type="checkbox"/> I authorize the above change in my beneficiary elections			
This signature is to: (1) verify the accuracy of the information contained on this card; and (2) to make the necessary authorization, if any.			
Date Signed	Signature of Insured		

RETURN THE COMPLETED COPY TO YOUR EMPLOYER