Accidental Death Beneficiary Designation

Name of Insured: _____ Date of Birth: _____
Address of Insured: _____
(Permanent Address) _____
_____

Primary Beneficiary (First Choice)
Name: _____ Date of Birth: _____
Address: _____
_____
_____
Relationship: _____
(Mother, Father, Etc.)
Secondary Beneficiary (Second Choice)
Name: _____ Date of Birth: _____
Address: _____
_____
_____
Relationship: _____
(Mother, Father, Etc.)

Signature of Insured: _____
Signed this _____ day of _____ of _____.
(Day) (Month) (Year)

Medical Release Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical facility or medical-related facility that has any records or knowledge of me or my health conditions, to release that information, in the event of a medical emergency, to Global Educational Concepts, Inc.

Full Name (Print):_____

Signature: _____

Date: _____

Social Security Release Authorization

I hereby authorize any social security officer or social security staff member to release any information regarding my social security card number or my application to Global Educational Concepts, Inc.

Full Name (Print):_____

Signature: ____ _____

Date: _____