

INSTRUCTIONS

This form allows you to designate who you want to receive your plan benefits upon your death.

This is a legal document. It should not contain any mark outs, erasures or correction fluid. Fill out and print this online form or print and complete the form using blue or black ink. The form must have a written **SIGNATURE** and **DATE**. Fax copies cannot be accepted.

- Please make sure you fill in your personnel number, Social Security number and name.
- In Section A, please write the name of at least one beneficiary. Fill in the beneficiary's social security number, relationship to you, date of birth and address. In the Payment % column, indicate the percentage of benefit you wish the beneficiary to receive. If only one beneficiary is listed, then the percentage of benefit is 100%. Please see your Associate Benefits Book for information regarding assignment of your plan benefits.

EXAMPLE:

Name <i>Mark Anderson</i>	Social Security Number <i>777-77-7777</i>	Relationship <i>Spouse</i>	Gender <i>Male</i>	Date of Birth <i>08/31/68</i>	Payment % <i>100%</i>
Street Address/City/State/Zip <i>2625 Central Ave. Lakeland, FL 33811</i>					

If multiple beneficiaries are listed each percentage must be a whole number (i.e. no decimals or fractions). The total combined percentage of benefit must equal 100% for this section.

EXAMPLE:

Name <i>Jane Q. Jones</i>	Social Security Number <i>999-99-9999</i>	Relationship <i>Sister</i>	Gender <i>Female</i>	Date of Birth <i>04/06/68</i>	Payment % <i>70%</i>
Street Address/City/State/Zip <i>522 E. Main St. Apt #10 Lakeland, FL 33811</i>					
Name <i>Ethel M. Smith</i>	Social Security Number <i>888-88-8888</i>	Relationship <i>Mother</i>	Gender <i>Female</i>	Date of Birth <i>11/15/39</i>	Payment % <i>30%</i>
Street Address/City/State/Zip <i>3455 Imperial Highway Anaheim, CA 93631</i>					

If you have more than four primary or contingent beneficiaries, please write additional beneficiaries on the back of the Beneficiary Designation Form.

- Repeat the beneficiary designation process for Contingent Beneficiary(ies) under Section B of the form.
- **Please complete the information, print, sign and date the form and return to:**
 Publix Super Markets, Inc.
 Group Benefits Department
 P.O. Box 32040
 Lakeland, FL 33802-2040
- If you have any questions, please contact the Group Benefits Department at 1-863-688-7407, ext. 52280, or toll-free 1-800-741-4332 (outside of Lakeland).

**Publix Super Markets, Inc.
Group Life Insurance Plan
BENEFICIARY DESIGNATION FORM**

Personnel #	Social Security Number					
Last Name			M.I.	First Name		
SECTION A Primary Beneficiary(ies) – The individual(s) who may receive payment of your life insurance benefit.					The combined total percentage of Section A must total 100%.	Total %
Name	Social Security Number	Relationship	Gender	Date of Birth	Payment %	
Street Address/City/State/Zip						
Name	Social Security Number	Relationship	Gender	Date of Birth	Payment %	
Street Address/City/State/Zip						
Name	Social Security Number	Relationship	Gender	Date of Birth	Payment %	
Street Address/City/State/Zip						
Name	Social Security Number	Relationship	Gender	Date of Birth	Payment %	
Street Address/City/State/Zip						

Minor, Incapacitated or Not Legally Competent Beneficiary: Publix Super Markets, Inc. cannot act as your legal counsel with regard to assigning a minor (not of legal age), an individual who is incapable of giving a valid release for payment or an individual who is not legally competent as a beneficiary. While you can assign such a person, Publix encourages you to seek legal advice before doing so. If there is insufficient legal documentation, it may be necessary for distribution to be made to the individual's legal guardian, as documented by a court order.

SECTION B Contingent Beneficiary(ies) – If the Primary Beneficiary(ies) has died before you and your Beneficiary form has not been updated by you, then the Contingent Beneficiary(ies) would receive your plan benefit.					The combined total percentage of Section B must total 100%.	Total %
Name	Social Security Number	Relationship	Gender	Date of Birth	Payment %	
Street Address/City/State/Zip						
Name	Social Security Number	Relationship	Gender	Date of Birth	Payment %	
Street Address/City/State/Zip						
Name	Social Security Number	Relationship	Gender	Date of Birth	Payment %	
Street Address/City/State/Zip						
Name	Social Security Number	Relationship	Gender	Date of Birth	Payment %	
Street Address/City/State/Zip						

I **understand** I am revoking any previous designation, and I hereby designate the person(s) listed above as beneficiary of any amount payable under the Group Life Insurance and AD&D Plan in the event of my death.

I **understand** when more than one beneficiary is designated, percentage payment will be made as elected to each Primary Beneficiary or to the surviving primary beneficiary(ies). If all Primary Beneficiaries are deceased, then percentage payment will be made as elected to each Contingent Beneficiary or to the surviving contingent beneficiary(ies). If the percentage of distribution is not specified or does not equal 100%, the beneficiary(ies) will share the benefit amount equally for each category.

Signature of Insured

Date