Pre-Existing Condition Exclusion Information. The plan includes a pre-existing condition exclusion, which means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will cover that condition. This exclusion applies only to conditions for which for which medical advice, diagnosis, care or treatment was recommended or received within a six-month period. The pre-existing condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 30 days after birth, adoption or placement for adoption. Generally, this six-month period begins six months before the day your coverage becomes effective. If you have a waiting period for coverage, the six-month period starts six months before the day the waiting period begins. This exclusion may last up to 12 months (or 18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period.

But you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion, as long as you haven't had a break in coverage lasting 63 days or more. To reduce the 12-month (or 18-month) exclusion period by the length of your creditable coverage, give us a copy of any certificates of creditable coverage you have. If you don't have a certificate, but you do have prior health coverage, we will help you get a certificate from your prior plan. There are also other ways that you can show your creditable coverage.

Please contact the Office of Employment Services & Benefits for the Diocese of Knoxville at 865-584-3307.

UNUM®

Group Life Insurance Request for Beneficiary Designation

Policy No.	Your Social Security No.	Policyholder's Name
551767 047		Diocese of Knoxville
Your Name (last, first, middle initial)		Beneficiary(ies) as of (date)

Primary beneficiary(ies)

Name	Social Security No.	Relationship to you	%* share
Address	City	State	Zip
Name	Social Security No.	Relationship to you	%* share
Address	City	State	Zip

Contingent beneficiary(ies)

Name	Social Security No.	Relationship to you	%* share
Address	City	State	Zip
Name	Social Security No.	Relationship to you	%* share
Address	City	State	Zip

The change will be effective in accordance with the Group Policy.

*Surviving beneficiaries will be paid equally unless otherwise indicated. This beneficiary change cancels and supersedes previous designations and may be changed upon written request.

Insured's Signature	Date Signed	Witness's Signature