

# COLI INCENTIVE BENEFIT PLAN – BENEFICIARY DESIGNATION

*For Eligible Employees*

Name: \_\_\_\_\_ Dow ID: \_\_\_\_\_ Soc Sec Number: \_\_\_\_\_

I do not want the beneficiary I designated for Company-Paid Life Insurance to be my COLI Incentive Benefit Plan beneficiary.

**I hereby revoke any previous designation of primary beneficiary(ies) and contingent beneficiary(ies) (if any) I made for the COLI Incentive Benefit Plan, and make the following revocable designation of primary beneficiary(ies) and contingent beneficiary(ies). *\*If you name a Trust as a beneficiary, you will need to insert the complete name of trust, date and location of trust. If this information is not on the form, the form will be returned.* (COMPLETE TRUST SECTION)**

**\*\*For employees who leave before retiring from Dow or participating Dow subsidiaries, the COLI Incentive Benefit is reduced to one-half of its original value and payable only to a Surviving Spouse or surviving Domestic Partner. *If there is no Surviving Spouse or surviving Domestic Partner, no COLI Incentive Benefit will be paid.***

### Primary Beneficiary Designation

NAME (SHOW GIVEN NAME)	RELATIONSHIP	DATE OF BIRTH	ADDRESS	IN EQUAL SHARES UNLESS OTHERWISE NOTED

**\*If you name a Trust as your beneficiary, please complete this section:**

**Trustee Designation** (applies only if a trust has been created in an executed trust agreement)

Name of Trustee(s) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

and successor(s) in trust, as Trustee(s) under \_\_\_\_\_  
(Title of Agreement)

Dated \_\_\_\_\_ executed by me and said Trustee(s).

Location of Trust \_\_\_\_\_

**In the event said primary beneficiary(ies) predecease me, I designate as contingent beneficiary(ies)**

### Contingent Beneficiary Designations

NAME (SHOW GIVEN NAME)	RELATIONSHIP	DATE OF BIRTH	ADDRESS	EQUAL SHARES
				If more than one contingent beneficiary, payment will be made in equal shares or to the survivors in equal shares.

**Beneficiary changes are not effective until the date received by Dow North America Benefits. If the beneficiary form is signed by an individual with Power of Attorney (POA), a copy of the POA must be attached and it must give the individual such authority.**

Date: \_\_\_\_\_

\_\_\_\_\_  
*(Signature of insured)*

*Return the completed form to:*

The Dow Chemical Company, Dow North America Benefits, PO Box 2169, Midland, MI 48641-2169