

GROUP DEATH IN SERVICE LIFE ASSURANCE SCHEME

The Landmark Hotel London offers Life Assurance, which is payable in the event of your death whilst under state retirement age and a permanent employee of The Landmark Hotel London.

If your Lifetime Allowance Limit (pension fund) in the current tax year is more than £1.25million, please tick in the box.

If you have ticked the above stated box, please contact the Director of Human Resources to discuss further.

If you have been refused life assurance, this benefit may not be available to you. If this is the case, please contact the Director of Human Resources as soon as possible to enable us to contact our life assurance company for advice.

Please note that if you opt out of the Group Life Scheme at any time and re-join at a later date, you will not automatically qualify for life assurance cover.

Please note you are required to meet all terms and conditions of the hotel and Life Assurance policy to be able to make a claim.

Minimum age required to join the scheme 16 years old.

This cover will cease at your state pension age even if you carry on working beyond this point.

To:	The Trustees of The Landmark London Group Death in Service Scheme
From:	Full Name: _____ Please complete in BLOCK CAPITALS

I refer to my membership of The Landmark London Group Death in Service Life Assurance Scheme and fully understand that in the event of my death my wishes for the disposal of my Benefits are as follows:

In the event of my death, I would like to nominate the following person(s) as beneficiaries of any benefits under the above scheme. This expression of wish supersedes any earlier dated expression.

When completed, pass it to Human Resources for safekeeping.

This form will then be held by the trustees until your death at which time they will have regard for your wishes when distributing any benefit payments.

I understand that the Trustees are not bound to act in accordance with my wishes in deciding to whom and in what proportions the sum shall be paid.

If your circumstances change, and you wish to change this expression of wish form, please ask Human Resources to provide you with a fresh form, and instruct them to destroy this one.

I understand that it is my sole responsibility to keep this information up to date, and failure you supply beneficiary information may result in the benefit not being paid.

Full Name	Current Address	Relationship	Proportion
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This form supersedes any nomination previously completed.

Signed: _____

Date: _____

