

Insured _____

Date of Birth _____

Certificate/Policy Number _____ Owner (if other than insured) _____

Mailing Address: Insured's or Owner's (if other than insured)

Street _____ City _____ State _____ Zip Code _____

Home Phone Number (____) _____ Work Phone Number (____) _____

I hereby revoke all prior designations of beneficiary and request the present designations below.

Primary Name	Soc. Sec. #/Tax ID	Date of Birth	Relationship	%*
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Contingent Name	Address	Soc. Sec. #/Tax ID	Date of Birth	Relationship	%*
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

*Unless otherwise directed, proceeds will be paid in equal shares to all primary beneficiaries who survive the Insured; but if none survive, proceeds will be paid in equal shares to all contingent beneficiaries who survive the Insured. Otherwise, to the owner or his estate.

SIGNATURES REQUIRED

If owner is an individual or partnership:

_____/_____
Signature of owner(s) _____ Date _____

Signature of owner's spouse (Required in AZ, CA, ID, LA, NV, NM, TX, WI, WA)

Signature of irrevocable beneficiary (if any)

If owner is a corporation:

Signature of Corporate Officer

Title

Signature of Corporate Officer

Title

Notary: On this day personally appeared before me the person(s) who executed this form and acknowledged that he or she (or they) signed the same as his or her (or their) free and voluntary act and deed for the uses and purposes therein mentioned.

Given under my hand and official seal this _____ day of _____.

Notary Signature

Please see Beneficiary Change Instructions.