



*First, Middle, Last*

Insured's Name \_\_\_\_\_ Policy Number \_\_\_\_\_

Owner's Home/Cell Phone (\_\_\_\_) \_\_\_\_\_ / (\_\_\_\_) \_\_\_\_\_ Owner's E-mail Address \_\_\_\_\_

The undersigned Policyowner hereby revokes any previous beneficiary designation with respect to any proceeds payable at the death of the Insured. Any such proceeds shall be paid as shown below.

- First, funds are paid to all primary beneficiaries who are living/existing when the Insured dies.
- If no primary beneficiaries are living/existing when the Insured dies, then funds are paid to contingent beneficiaries who are living/existing.
- If no beneficiary is living/existing when the Insured dies, then funds are paid to the owner or owner's estate.
- When more than one living/existing beneficiary is in a class, funds are paid in equal shares unless otherwise designated. When unequal shares are listed, and any die/cease to exist before the Insured, each living/existing beneficiary in this class is paid in proportion to each one's listed share.
- If primary or contingent beneficiaries include percentages, the total of each category must equal 100 percent.
- When children are beneficiaries and not named individually, all living and future children born to or adopted by the Insured are included unless otherwise designated. Unless named individually, stepchildren are not included.
- An irrevocable beneficiary must consent to a change of beneficiary, but has no other rights.
- This beneficiary designation voids all earlier primary or contingent beneficiary designations.

**1. Primary Beneficiary(ies) –**

| Full Name | Mailing Address | Relationship to Ins. | Date of Birth | Social Security No. | Percentage |
|-----------|-----------------|----------------------|---------------|---------------------|------------|
|           |                 |                      |               |                     |            |
|           |                 |                      |               |                     |            |
|           |                 |                      |               |                     |            |
|           |                 |                      |               |                     |            |
|           |                 |                      |               |                     |            |
|           |                 |                      |               |                     |            |

**2. Contingent Beneficiary(ies) –**

| Full Name | Mailing Address | Relationship to Ins. | Date of Birth | Social Security No. | Percentage |
|-----------|-----------------|----------------------|---------------|---------------------|------------|
|           |                 |                      |               |                     |            |
|           |                 |                      |               |                     |            |
|           |                 |                      |               |                     |            |
|           |                 |                      |               |                     |            |
|           |                 |                      |               |                     |            |
|           |                 |                      |               |                     |            |

\_\_\_\_\_  
*Date (MM/DD/YYYY)*

\_\_\_\_\_  
*Signature of Owner*

\_\_\_\_\_  
*Signature of Witness (A non-related person with no financial interest in the policy.)*

\_\_\_\_\_  
*Signature of Joint Owner*

The Insurer has acknowledged and recorded the above designation.

\_\_\_\_\_  
*Date (MM/DD/YYYY)*

\_\_\_\_\_  
*Authorized Signature*

