American Life & Security Corp

Executive Office
P.O. Box 5577 • LINCOLN NE 68505-5577
Phone: 402.489.8266 • Fax: 402.489.8295

BENEFICIARY CHANGE FORM

Insured _____ Policy # _____

INSTRUCTIONS

1. This Beneficiary Designation cancels all prior Beneficiary Designations and settlement agreements for the Policy identified by the number above.
2. Print the beneficiary's full name, address and relationship to the Insured. The Policy's death benefit will be paid to multiple beneficiaries in equal shares unless otherwise indicated. For multiple beneficiaries of unequal shares, indicate each beneficiary's share in percentage (must equal 100%) of the Policy's Death Benefit next to their names.
3. A form which has been altered or on which there has been an erasure cannot be accepted unless the alteration is initialed by the policy owner.
4. The form must be notarized.
5. This form is to be forwarded to the Company. A confirmation of the beneficiary change will be sent to you for your records.
6. **Irrevocable Beneficiaries:** An irrevocable beneficiary is a designation that cannot be changed without the irrevocable beneficiary's written consent. It is also a designation that for any change (i.e. withdrawal, ownership change, etc.) to the policy/contract, we will require the irrevocable beneficiary to sign and date the request. To add an irrevocable beneficiary they must sign the form.
7. **Beneficiary Classes (unless otherwise specified in the designation):**
   PRIMARY or the first person (s) in line to receive the death proceeds after the insured is deceased.
   CONTINGENT or the second or subsequent person (s) in line to receive the death proceeds after the insured is deceased and no surviving primary beneficiary (ies).

PRIMARY BENEFICIARY

*Required Fields

Full name *	Complete Address *	Telephone Number *	Date of Birth *	Relationship to the Insured *	SSN *	Percentage

Policy #_____

CONTINGENT BENEFICIARY

*Required Fields

Full name *	Complete Address *	Telephone Number *	Date of Birth *	Relationship to the Insured *	SSN *	Percentage

Signed at _____, _____
City State

This _____ day of _____, _____
Day Month Year

X_____, _____
Owner's Signature Owner's Social Security #

X_____, _____
Co-Owner's Signature Co- Owner's Social Security #

X_____
Irrevocable beneficiary (if applicable)

_____ _____
Owner's email address Owner- Day time Phone __Home __Cell __Work

_____ _____
Co-Owner's email address Co- Owner- Day time Phone __Home __Cell __Work

Subscribed and sworn before me this _____ day of _____, _____.

County of: _____

State of: _____ *My commission expires on_____*

_____
Notary Public