TRANSAMERICA EMPLOYEE BENEFITS

Return Completed Forms to:
Transamerica Employee Benefits
P.O. Box 8063
Little Rock, Arkansas 72203-8063
(888) 763-7474
Fax: (866) 945-8691
www.transamericaemployeebenefits.com

Request for Policy Service (Beneficiary Changes)

1. Policy Owner and Insured Information for Policy Company: TRANSAMERICA LIFE INSURANCE COMPANY

Policy Owner Social Security No.	Policy Owner Name (Last, First, M.I.)	
Insured Social Security No.	Insured Name (Last, First, M.I.)	
Policy No. 791323261	Employer Name	SD No.

2. Beneficiary Changes

I hereby revoke any and all prior beneficiary designations and existing settlement agreements, if any, and elect to change the beneficiary(ies) under the above numbered policy as follows:

Primary Beneficiary(ies): For multiple beneficiaries, payment will be made in equal shares unless otherwise noted below.

Full Name (as it should appear on company records)	%	Street Address	City/State/Zip	Relationship	Date of Birth

Contingent Beneficiary(ies): Receives proceeds only if all Primary Beneficiaries predecease the Insured. For multiple beneficiaries, payment will be made in equal shares unless otherwise noted.

Full Name (as it should appear on company records)	%	Street Address	City/State/Zip	Relationship	Date of Birth

It is understood and agreed that, unless otherwise directed, proceeds will be paid in accordance with the policy provisions.

3. Signatures

I/We understand and agree that my/our signature(s) below shall apply to each request which has been checked on this form and further agree that no request will become effective which is not checked. I/We agree that these changes shall become part of the policy. I/We request that any provisions in said policy requiring its endorsement to effect the change requested be waived and that these changes be effective upon completion and execution of this form and approval hereof by the company at its Administrative Office. I/We certify that no insolvency or bankruptcy proceedings are now pending against me/us.

Signed in (City/State) _____ This _____ Day of (Month/Year) _____.

Current Policy Owner _____ Witness _____

Policy Owner Marital Status ☐Married ☐Single

Spouse (required in community property states.)* _____ Witness _____

Assignee (if applicable) _____ Witness _____

Instructions

Item# 1 Enter policy owner name and social security number, insured name and serial number, and policy or certificate number. Always include the name of all Insured parties and Employer's name. Please provide us with the Salary Deduction case number (if available).

Item# 2 If you are selecting multiple beneficiaries, be sure to include the percentage amount that you would like for each beneficiary to receive, otherwise payment will be made in equal shares. If the proposed beneficiary is a married woman, use her own given and maiden names and her husband's surname (e.g., "Mary Joan Smith Jones", not "Mrs. John J. Jones").

Item# 3 The following signatures are required:

(a) Policy Owner (If there are 2 or more co-owners, the signatures of each co-owner are required)

*(b) Spouse of Policy Owner (*If Married, Spouse of Policy Owner must sign if residence is in one of the community property states of: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin.*)

(c) Assignee (If any)

(d) **EACH SIGNATURE MUST BE WITNESSED BY A DISINTERESTED PARTY.**

ALL SIGNATURES MUST BE WRITTEN IN INK AND WRITTEN EXACTLY AS THE NAME IS GIVEN IN THE POLICY OR ASSIGNMENT.

FOR ADMINISTRATIVE OFFICE USE ONLY

The above requested policy changes are herby acknowledged and recorded on the books of the Company indicated above. Endorsement of such change on said policy is hereby waived.

Date Recorded _____ By _____

* Spouse or equivalent, as defined by governing state law.

Any reference above to "spouse" or ""marriage" includes the equivalent if applicable or as provided by governing law.