

We ask for detailed information about your beneficiary(ies). This information will help us identify and pay the appropriate beneficiary(ies) at the death of the insured, which may be many years after you make this designation. To ensure we satisfy our claims obligations, we sometimes use social security number(s) and birthday(s) to identify and locate each beneficiary to whom we owe payments. Listed in the boxes below are the key pieces of information we need in each section of the Change of Beneficiary Form.

Please help us ensure we pay your beneficiary(ies) quickly and accurately by providing as much of the requested information as you can. Thank you for your time.

INSTRUCTION PAGE: PLEASE DO NOT WRITE ON THIS PAGE.

Section A	<ul style="list-style-type: none"> • Insured's Name • Policy Number
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Section B	<ul style="list-style-type: none"> • Beneficiary(ies) Name(s) • Beneficiary(ies) Date(s) of Birth • Percent of Proceeds payable to each Beneficiary Total percent must equal 100% for each type of beneficiary. The primary beneficiaries must total 100%. The 1st Contingent Beneficiary(ies) must total 100%. The 2nd Contingent Beneficiary(ies) must total 100%. • Beneficiary(ies) Social Security Number(s) or Tax ID Number(s) • Beneficiary(ies) Relationship to Insured • Beneficiary(ies) Address(es) • If designating a Trust, provide the Trust name, date and address • If designating an estate, enter "Estate of Insured" on designation line <p>If you should need more space than is provided on our form, please attach additional pages. Each page must include a policy number, date and the owner signature(s).</p>
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Section C	<p>Signature requirements (vary based on ownership of policy). Examples are:</p> <ul style="list-style-type: none"> • Individual: Print and sign your name exactly as it appears on your policy. If your name has changed, a Name Change form is required. • Multiple Owners: <u>All</u> owners must sign. • Partnership: <u>All</u> partners must sign (unless we have a form, signed by all partners, authorizing one partner to sign.) • Corporation: An officer, other than the insured, must sign indicating their position in the corporation. Please provide a Corporate Resolution granting signature authority. • Trust: The current trustee(s) must sign. (A Certification of Trust form is also required.) • Important Note: The owner of the policy(ies) must sign the form and their signatures must be witnessed.
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A. Policy Information

Original form must be returned for processing.

Insured's Name

Policy Number(s)

B. Beneficiary Designation

I designate the following as beneficiary(ies) to receive any death benefit that becomes payable under this policy contract. Payment will be made to the beneficiary(ies) that survive the insured, successively, in the following order, in the percentages indicated. (Percentages for Primary Beneficiary(ies) must equal 100% and percentages for 1st Contingent Beneficiary(ies) must equal 100% and percentages for 2nd Contingent Beneficiary(ies) must equal 100%)

1. Primary Beneficiary(ies)
2. Then 1st Contingent Beneficiary(ies) (If no primary living at the death of the Insured)
3. Then 2nd Contingent Beneficiary(ies) (If no primary, or 1st Contingent Beneficiary living at the death of the Insured)
4. The estate of the last surviving beneficiary unless governed by a contractual provision stating otherwise.

I reserve the right to revoke or change any beneficiary designation in the future. I revoke any previous beneficiary designations and settlement agreements that apply to the amount payable under the policy in the event of my death. Any person to receive proceeds of this policy must be listed on this form.

_____ Beneficiary's Name (First, Middle Initial, Last), Entity Name or Estate				
_____ Percent (%) of death benefit	_____ Date of Birth/Date of Trust	_____ Social Security Number /Tax ID No.		
Relationship to Insured	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Trust	<input type="checkbox"/> Other _____
_____ Street Number	_____ Street Name	_____ City	_____ State	_____ Zip Code
• Check One (If nothing checked, the designation will be Primary)				
<input type="checkbox"/> Primary		<input type="checkbox"/> 1st Contingent		<input type="checkbox"/> 2nd Contingent

_____ Beneficiary's Name (First, Middle Initial, Last), Entity Name or Estate				
_____ Percent (%) of death benefit	_____ Date of Birth/Date of Trust	_____ Social Security Number /Tax ID No.		
Relationship to Insured	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Trust	<input type="checkbox"/> Other _____
_____ Street Number	_____ Street Name	_____ City	_____ State	_____ Zip Code
• Check One (If nothing checked, the designation will be Primary)				
<input type="checkbox"/> Primary		<input type="checkbox"/> 1st Contingent		<input type="checkbox"/> 2nd Contingent

Change of Beneficiary Form

Policy #(s) _____

_____ Beneficiary's Name (First, Middle Initial, Last), Entity Name or Estate				
_____ Percent (%) of death benefit	_____ Date of Birth/Date of Trust	_____ Social Security Number /Tax ID No.		
Relationship to Insured <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Trust <input type="checkbox"/> Other _____				
_____ Street Number	_____ Street Name	_____ City	_____ State	_____ Zip Code
• Check One (If nothing checked, the designation will be Primary) <input type="checkbox"/> Primary <input type="checkbox"/> 1st Contingent <input type="checkbox"/> 2nd Contingent				

_____ Beneficiary's Name (First, Middle Initial, Last), Entity Name or Estate				
_____ Percent (%) of death benefit	_____ Date of Birth/Date of Trust	_____ Social Security Number /Tax ID No.		
Relationship to Insured <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Trust <input type="checkbox"/> Other _____				
_____ Street Number	_____ Street Name	_____ City	_____ State	_____ Zip Code
• Check One (If nothing checked, the designation will be Primary) <input type="checkbox"/> Primary <input type="checkbox"/> 1st Contingent <input type="checkbox"/> 2nd Contingent				

_____ Beneficiary's Name (First, Middle Initial, Last), Entity Name or Estate				
_____ Percent (%) of death benefit	_____ Date of Birth/Date of Trust	_____ Social Security Number /Tax ID No.		
Relationship to Insured <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Trust <input type="checkbox"/> Other _____				
_____ Street Number	_____ Street Name	_____ City	_____ State	_____ Zip Code
• Check One (If nothing checked, the designation will be Primary) <input type="checkbox"/> Primary <input type="checkbox"/> 1st Contingent <input type="checkbox"/> 2nd Contingent				

Attached is/are _____ (# of pages) that are to be made a part of this change. Each page must be dated, signed, and include the applicable policy number(s).

Change of Beneficiary Form

Policy #(s) _____

C. Signature and Date

Form must be signed by owner and witness

Individual Owner

This beneficiary change is effective only when recorded by the company at its home office and is effective as of the date signed by the owner. The company shall not be liable for payment to the beneficiary(ies) listed in Section B if the claim obligation was satisfied prior to the recording of this form. The company may use proof by affidavit or other evidence deemed satisfactory to determine the persons comprising a class of beneficiaries. Any payment made by the company relying on such proof, to the extent of such payment, shall be a valid discharge of the company's obligation under the policy. If a Testamentary Trust is named as beneficiary and the Will naming the trust is not probated within 180 days from the date of the Insured's death, the proceeds shall be paid as if a beneficiary did not survive the Insured. I make this change as allowed in my policy, subject to the terms and conditions therein, as well as any assignment. I expressly reserve the right to change the beneficiary in the future any time I may elect.

Signature: _____ Printed Name: _____ Date: _____
Owner
Joint Owner

Witness (Form must be witnessed. In Massachusetts, the witness cannot also be your beneficiary.)

Non Individual Owner

This beneficiary change is effective only when recorded by the company at its home office and is effective as of the date signed by the owner. The company shall not be liable for payment to the beneficiary(ies) listed in Section B if the claim obligation was satisfied prior to the recording of this form. The company may use proof by affidavit or other evidence deemed satisfactory to determine the persons comprising a class of beneficiaries. Any payment made by the company relying on such proof, to the extent of such payment, shall be a valid discharge of the company's obligation under the policy. If a Testamentary Trust is named as beneficiary and the Will naming the trust is not probated within 180 days from the date of the Insured's death, the proceeds shall be paid as if a beneficiary did not survive the Insured. I make this change as allowed in my policy, subject to the terms and conditions therein, as well as any assignment. I expressly reserve the right to change the beneficiary in the future any time I may elect.

Full name of Entity, Trust, or Corporation *

Signing in the capacity as: [] Trustee [] Officer _____ [] Other _____
(List Corporate Title)

Signature: _____ Print Name: _____ Date: _____
A) _____
B) _____

Witness * Corporate Resolution required if corporation.

This space for Home Office use only

TEXAS LIFE INSURANCE COMPANY

Date Recorded

By _____
Associate Director of Insurance Services