Independent Life

# BENEFICIARY DESIGNATION FORM

## PAYEE INFORMATION

Please enter information as we currently have on file.

Policy/Contract Number: _____

First Name: _____ Last Name: _____

Address/City/State/ZIP Code: _____

Email: _____ Phone: _____

Social Security Number: _____ Date of Birth: _____

## BENEFICIARY INFORMATION

Please enter the person(s) to receive the remainder of the proceeds in the event the payee dies. Attach additional sheet if necessary. Beneficiary percentages must total 100% for Primary, and 100% for Contingent (if applicable).

Name: _____ Relationship: _____ %: _____

○ Primary ○ Contingent

Address/City/State/ZIP Code: _____

Phone: _____ Social Security Number: _____ Date of Birth: _____

Name: _____ Relationship: _____ %: _____

○ Primary ○ Contingent

Address/City/State/ZIP Code: _____

Phone: _____ Social Security Number: _____ Date of Birth: _____

Name: _____ Relationship: _____ %: _____

○ Primary ○ Contingent

Address/City/State/ZIP Code: _____

Phone: _____ Social Security Number: _____ Date of Birth: _____

## AUTHORIZATION

I request that the contingent payee(s) be changed in accordance with the contract's provisions. I represent that all statements and information contained herein are true and complete to the best of my knowledge and belief. This request replaces all prior contingent payee designations which are hereby revoked. This request relates only to the contract referenced above and no other contracts.

_____ _____ _____

Payee or Guardian Signature | Print Name | Date (mm/dd/yy)

_____ _____ _____

Witness Signature (must be a third party, disinterested adult) | Print Name | Date (mm/dd/yy)

Please complete this form in full, sign and submit along with any required legal documents to:
Email: documents@Independent.Life | Fax: 214.666.4833
Mail: Independent Life Insurance Company, P.O. Box 679053, Dallas, Texas 75267-9053
Questions? Call 800.793.0848