

Protective Life Insurance Company

Life and Health Insurance Administration | P.O. Box 12687 | Birmingham, AL 35202-6687
Fax: 205-268-3402 | Email: service@protective.com

Policy Number:	Insured(s):
Owner(s):	

CHANGE OF BENEFICIARY

I (we) hereby request that all previous beneficiary designations and directions for settlement of this policy be cancelled and that the proceeds of said policy upon the death of the insured be paid, in one sum, unless otherwise provided herein or in said policy, as follows:

PRIMARY BENEFICIARY: (Print full names and relationships to the insured)

Primary Beneficiary full name	SSN/Tax ID	%
Address		
Relationship to Insured	Phone Number	Date of Birth/Trust Date (mm/dd/yyyy)

Primary Beneficiary full name	SSN/Tax ID	%
Address		
Relationship to Insured	Phone Number	Date of Birth/Trust Date (mm/dd/yyyy)

Primary Beneficiary full name	SSN/Tax ID	%
Address		
Relationship to Insured	Phone Number	Date of Birth/Trust Date (mm/dd/yyyy)

Primary Beneficiary full name	SSN/Tax ID	%
Address		
Relationship to Insured	Phone Number	Date of Birth/Trust Date (mm/dd/yyyy)

Primary Beneficiary full name	SSN/Tax ID	%
Address		
Relationship to Insured	Phone Number	Date of Birth/Trust Date (mm/dd/yyyy)

Policy No: _____

CONTINGENT BENEFICIARY: (Print full names and relationships to the insured)

Contingent Beneficiary full name	SSN/Tax ID	%
Address		
Relationship to Insured	Phone Number	Date of Birth/Trust Date (mm/dd/yyyy)

Contingent Beneficiary full name	SSN/Tax ID	%
Address		
Relationship to Insured	Phone Number	Date of Birth/Trust Date (mm/dd/yyyy)

Contingent Beneficiary full name	SSN/Tax ID	%
Address		
Relationship to Insured	Phone Number	Date of Birth/Trust Date (mm/dd/yyyy)

Contingent Beneficiary full name	SSN/Tax ID	%
Address		
Relationship to Insured	Phone Number	Date of Birth/Trust Date (mm/dd/yyyy)

Contingent Beneficiary full name	SSN/Tax ID	%
Address		
Relationship to Insured	Phone Number	Date of Birth/Trust Date (mm/dd/yyyy)

Elect Common Disaster Day Clause (Maximum of 30 days):

If any beneficiary shall die simultaneously with the insured or not be living on the _____ day following the death of the Insured, payment shall be made to the beneficiary(s) as if such beneficiary so dying had not survived the Insured.

Policy No: _____

Beneficiary Info and Guidelines:

- All beneficiary changes MUST include the designation of a primary beneficiary. Even if you only want to change the contingent beneficiary, you must confirm the primary beneficiary. If you wish to designate more than five individuals as primary or contingent beneficiaries, attach spreadsheet listing the additional beneficiaries including all details requested in this form and identifying their role as a primary or contingent beneficiary.
- Use percentages to indicate how proceeds are to be paid to both Primary and Contingent Beneficiaries. Please ensure these percentages total 100 each for both primary and contingent sections.
- If there are no percentages indicated, payment will be in equal shares to the surviving primary beneficiary(s). If there are no surviving primary beneficiary(s), then the proceeds will be paid to the contingent beneficiary(s). If there is no surviving contingent beneficiary(s), then the proceeds will be paid to the executors, administrators, or assigns of the owner.
- NAMING A MINOR AS A BENEFICIARY (see Designation Information for additional detail): If a beneficiary is a minor at the time of death of the insured, it may be necessary to delay the payment of the death benefit until a court appoints a guardian of the estate of the minor. Before naming a minor as beneficiary, we recommend you consult an attorney about options, such as creating and naming a trust, making a designation under your state's Uniform Transfers to Minors Act, or other beneficiary designations.

SIGN HERE FOR THE ABOVE REQUEST(S)

Please read the Signature Requirements to avoid a delay in processing.

Any person who knowingly with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material, thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties according to state law.

California policy/contract holders: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

_____	_____	_____
Witness	Owner Signature	Date

	Owner Current Address	

	Owner Daytime Phone Number	

_____	_____	_____
Witness	Owner Signature	Date

	Owner Current Address	

	Owner Daytime Phone Number	

Policy No: _____

Designation Information:

Naming Custodian for Minor Child

When naming a custodian for a minor child, please use the following verbiage:

(Name of Custodian) as custodian for (Name of Minor Child) under the (state in which child resides) Uniform Transfers to Minors Act.

Note: Only one Custodian per minor beneficiary

Any designation referencing children of the Insured shall be construed to mean such lawful (including those living, born later or legally adopted) children of the Insured as shall survive the Insured, unless otherwise limited by me in this request.

Please choose your delivery method below:

Please provide your email address to receive confirmation of this change via secure email. A confirmation will be sent directly to you and no login or account information will be required for you to access it.

If you elect not to provide your email address or the email address you provide is returned undeliverable, the acknowledgement will be sent via US Postal Service First Class Mail to the address of record.

Email: _____

If you wish to receive our acknowledgement via fax, please provide your fax number, including the area code.

Fax Number including area code: _____

Signature Requirements

1. Please complete the forms in BLACK ink to ensure that they are legible for processing.
2. If the policy is assigned, the Assignee does not have to sign.
3. If the Owner resides in a community property state, we recommend that the Owner's spouse join in signing this form. This is for the protection of both parties.
4. If the policy is owned by a corporation, partnership, association or company, this form should be signed by an Officer other than the Insured. The title of the Officer signing the form must also be included. If the Insured is the only officer of the company, please give us a signed statement to that effect on company letterhead.
5. If the policy is trust owned, please send a full copy of the Certificate of Trust or the sections of the trust that indicate the title of the trust, pages that list that Trustee/C-Trustees/Successor Trustees, trustee rights, any pages pertaining to the Life Insurance policy and the signature page. All applicable Trustees must sign.
6. If signing this form on behalf of the policy owner, please send ALL pages of the POA, Guardianship/Conservator paperwork, or other legal documentation. The POA/Guardian, etc. must sign their own name with the appropriate title behind their signature.
7. Signatures should be witnessed by a disinterested party of legal age.