Wilco Life Insurance Company
844-877-6907

INSTRUCTIONS - BENEFICIARY CHANGE REQUEST

Policy is NOT to be returned for this change to take place.

1. This form is not acceptable unless it is fully completed, dated, properly signed and submitted to the company within six months of signing the form. Altered forms cannot be accepted. This includes erasures, corrections and the use of whiteout on the form. If you need to make a change to a completed form, please contact us for another form.

2. **Beneficiary Designations:**
   - If more than one Beneficiary is named, state the exact manner in which they are to share in the proceeds by using percentages. The percentages must equal 100%.
   - Be sure to state full names, and relationships ("Mary Doe, wife of the insured" or "Jane and Jim Doe, children of the insured.")
   - If you are attaching a separate page with additional beneficiary designations, please be sure that the following are included on the separate page:
     - The policy number and insured's name
     - State full name and relationships of each beneficiary
     - Indication of whether the beneficiary is a Primary or Contingent Beneficiary
     - If multiple beneficiaries the designated percentage for each beneficiary
     - The additional page is to also be signed and dated by the policyowner
   - **If naming a Trust**, please include the full name of the Trust, including the Date of the Trust, the Tax ID Number, and trustee name(s).

3. Executing a beneficiary change revokes all previous beneficiary designations.

4. A separate Change of Beneficiary and Ownership Change Request form should be used for each policy.

5. **If policy is corporately owned,** two officers of the Corporation, **other than the Insured,** must sign on behalf of the Corporation, indicating their corporate title. Please submit legal documentation listing the currently authorized signers for the company. This information should be on company letterhead or be a copy of the corporate minutes.

6. **If you are the sole owner of the corporation check the box on the form.** Please submit legal documentation listing the currently authorized signers for the company. This information should be on company letterhead or be a copy of the corporate minutes.

7. If policy is owned by a partnership a minimum of two partners must sign.

8. If policy has multiple named owners, all owners must sign.

9. If policy has an Irrevocable Beneficiary, Irrevocable Beneficiary must sign.

10. All signatures must be in ink and should match the name as shown on the policy or

assignment. However, if a signature is missing a middle name or initial, prefix, suffix, and/or the first name is abbreviated (i.e. Jim instead of James) the signature can be accepted. In the case of a name change for a reason other than marriage or divorce, we require legal proof of the change such as a Court Order or Social Security Card.

11. **Spouse** – For the protection of both parties, if the owner resides in a Community Property State, we recommend that the owner's spouse join in signing and dating this form. If the owner resides in CA, ID, NV or WA the owner's spouse must sign and date this form.

12. The relationship of the proposed beneficiary to the person whose life is insured is needed for the purpose of identification. If no relationship exists, please furnish other information that will serve to identify the beneficiary.

13. **Examples Of Typical Beneficiary Designations**

The following examples represent the most common beneficiary designations.

- **Minor Children** should not be named as beneficiary since proceeds cannot be made payable to minors. If a beneficiary is a minor at the time proceeds are payable, we will require court documentation of the appointment of a Guardian of the Minor's Estate. In lieu of naming a minor as a beneficiary we recommend that you name an adult under the Uniform Gift to Minors Act (or Uniform Transfer to Minors Act depending on the state). Wording example: John Doe, Son of the Insured, if he has reached the age of majority. If John has not reached the age of majority, then to Mary Doe, Mother of John Doe, for John Doe under the Uniform Gift to Minors Act (or Uniform Transfer to Minors Act).
- **Multiple Beneficiaries**: John H. Doe, Father 75%; Mary E. Doe, Mother 15%; and Jane Doe, Sister 10%. Percentages must equal 100%.
- **Trust Beneficiary**: The ____(exact name of trust) Trust __(trustees names) as trustee(s) under written trust agreement dated _____. __(Tax ID #)
- **Partnership Beneficiary**: Smith, Jones and Brown, a partnership consisting of John A. Smith, William Jones and Henry Brown.
- **Common Disaster Clause**: Mary E. Doe, Wife, if living on the day after the death of the Insured; otherwise to John Doe, Son, and Jane Doe, Daughter, equally or the survivor.
- **Irrevocable Beneficiary**: Mary E. Doe, Wife, Without Reserving the Right to Change the Beneficiary. (If this type of designation is made, the consent of such beneficiary or beneficiaries will be required to exercise a subsequent right or privilege under said policy, including the right to designate a new beneficiary.)
- **Estate as Beneficiary**: The estate of John H. Doe, Insured.
- **Funeral Home Beneficiary**: If you reside in a state other than Illinois, Michigan, Missouri, New Jersey, New York, Oklahoma, and Texas, you may name a funeral home as beneficiary under a life insurance policy. If naming a funeral home as beneficiary, please include the exact name of the funeral home and the phrase "as their interest may appear." Please be aware that if the funeral home's interest is less than the death proceeds and they are listed as the only beneficiary, they are under no obligation to give any remaining funds to your family or estate. We recommend that you still name a trusted family member or friend as contingent beneficiary.

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BENEFICIARY CHANGE REQUEST

Insured:	Policy No.:
Owner's Tax ID:	Owner's Daytime Phone Number: ( )

PLEASE PRINT FULL NAME AND RELATION TO INSURED. INCLUDE THE ADDRESS AND TAX ID NUMBER.

- All prior beneficiaries and payment methods are revoked.
- Pay the proceeds at death in a single sum.
- Unless stated otherwise, proceeds will be paid in equal shares when more than one beneficiary is listed. Percentages must equal 100%.
- If no designated beneficiary lives to receive payment, unless stated otherwise in the policy, proceeds will be paid to the insured's estate.
- If the current Policy Owner resides in the state of Massachusetts, the signature of a disinterested witness is required. A disinterested person is described as anyone other than a designated beneficiary and over 18 years of age. An agent may not sign as a disinterested witness.
- If more space is needed affix additional document and include policy number, full name and relationships of each beneficiary, all applicable signatures on any attachments, date and sign.

PRIMARY BENEFICIARY 1:		
NAME:		Percentage: Telephone Number:
Mailing Address:		
City:	State:	Zip:
SS Number/Tax ID Number:	Date of Birth/Date of Trust:	Relationship to Insured:

PRIMARY BENEFICIARY 2:		
NAME:		Percentage: Telephone Number:
Mailing Address:		
City:	State:	Zip:
SS Number/Tax ID Number:	Date of Birth/Date of Trust:	Relationship to Insured:

CONTINGENT BENEFICIARY 1:		
NAME:		Percentage: Telephone Number:
Mailing Address:		
City:	State:	Zip:
SS Number/Tax ID Number:	Date of Birth/Date of Trust:	Relationship to Insured:

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BENEFICIARY CHANGE REQUEST/Continued

Insured:	Policy No.:

CONTINGENT BENEFICIARY 2:		
NAME:		Percentage: Telephone Number:
Mailing Address:		
City:	State:	Zip:
SS Number/Tax ID Number:	Date of Birth/Date of Trust:	Relationship to Insured:

Signatures (see instruction sheet for signature requirements):

Individual, Joint or Multiple Owners Signature Section (All owners must sign.)

Owner Signature _____ Date Signed _____

Joint Owner Signature _____ Date Signed _____

Assignee Signature _____ Date Signed _____

Irrevocable Beneficiary Signature _____ Date Signed _____

Disinterested Witness Signature _____ Date Signed _____

Corporate, Partnership or Trust Owned Signature Section

_____ _____

Printed Name of Corporation, Partnership or Full Name of Trust — Date of Trust

Printed Name of Corporate Officer or Trustee	Signature of Corporate Officer or Trustee	Title	Date Signed

☐ I am the sole officer of the corporation listed

Printed Name of Corporate Officer or Trustee	Signature of Corporate Officer or Trustee	Title	Date Signed

Spousal Signature Requirements

For the protection of both parties, if the owner resides in a Community Property State, we recommend that the owner's spouse join in signing and dating this form. If the owner resides in CA, ID, NV or WA the owner's spouse must sign and date this form below.

Spouse's Signature _____ Date Signed _____

Notary Signature if required

Subscribed and sworn to before me this _____ day of _____, 2_____

_____ _____

Signature of Notary (official stamp/seal required) — My Commission Expires

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Insured, Owner and Beneficiary Location Information

Policy/Contract No. _____

On another form provided to you by the Company, you are requesting the reinstatement of a policy, or a change to the owner or beneficiary(ies) of an existing policy. Prior to processing any such request, **New York Insurance Regulation 200** requires that we request the name, address, telephone number and social security number of the parties to the transaction. Consequently, in connection with the request you are concurrently submitting; please furnish the applicable information requested below. **This form should be submitted with your reinstatement or change request.**

The parties listed below should match those currently designated in this policy or any change in those parties being concurrently requested. Please consult your policy, including any endorsements, to obtain the policy's current owner and beneficiary information. If you need assistance, we encourage you to contact us at 844-877-6907.

NOTE: The completion of this form by itself does not update or change the owner or any beneficiary designated to receive the benefits of this policy.

Owner Information

Name:_____

Address:_____

SSN:_____/_____/_____ Phone: _____-_____-_____ DOB: _____

Insured Information

Name:_____

Address:_____

SSN:_____/_____/_____ Phone: _____-_____-_____ DOB: _____

Beneficiary Information

Name:_____

Address:_____

SSN:_____/_____/_____ Phone: _____-_____-_____ DOB: _____

Continue on the back if more space is needed.