OneMain Solutions

Underwritten by:
American Health and Life Insurance Company
P.O. Box 2548 Fort Worth, TX 76113-2548
Toll Free 800-307-0048 | Fax 800-350-9306
inspolicysvcs@omf.com

Insured's Name _____ Policy # _____ SSN _____

Change of Beneficiary Request Form

Insured's date of birth	Telephone #
Mailing address City State Zip	

I hereby request that all prior beneficiary designation(s) provided under the above numbered certificate/policy be voided and that the following designation(s) shall apply.

PRIMARY BENEFICIARY(IES): Person or persons who will receive the life insurance proceeds upon your death. If additional space is needed, please use a separate paper that is signed and dated by the Insured or Owner and a witness and attach it to this form.

Total percentages for Primary Beneficiary(ies) should add up to 100%. If no percentages are indicated, the proceeds will be divided equally. If payable to a Trust, please list the full name and date of the Trust. The Insurance Company will not be required to investigate the Trust's authority or its use of funds.

Primary Beneficiary full legal name	Date of birth/trust date	SSN/TIN	%
Mailing address	Relationship to Insured	Telephone #	
Primary Beneficiary full legal name	Date of birth/trust date	SSN/TIN	%
Mailing address	Relationship to Insured	Telephone #	
Primary Beneficiary full legal name	Date of birth/trust date	SSN/TIN	%
Mailing address	Relationship to Insured	Telephone #	

I understand that this beneficiary designation must be recorded by the Administrator to be in effect, but when recorded, will take effect as of the date I signed this request. I also understand that the Administrator will not record any beneficiary designation received after the date of death of the Primary Insured on the above numbered certificate/policy. I further understand and agree that any payment made prior to the receipt of this beneficiary designation will not be affected.

Signature of Primary Insured or Owner		Date
Signature of witness (cannot be Beneficiary)	Address of witness	Date

Recorded by the Company on _____ By _____ **This beneficiary designation will not become effective until recorded by the Company. **

See reverse side for contingents.

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Insured's Name _____ Policy # _____ SSN _____

CONTINGENT BENEFICIARY(IES): Person or persons who will receive the life insurance proceeds if there is no surviving Primary beneficiary. If additional space is needed, please use a separate paper that is signed and dated by the Insured or Owner and a witness and attach it to this form.

Total percentages for Contingent Beneficiary(ies) should add up to 100%. If no percentages are indicated, the proceeds will be divided equally. If payable to a Trust, please list the full name and date of the Trust. The Insurance Company will not be required to investigate the Trust's authority or its use of funds.

Contingent Beneficiary full legal name	Date of birth/trust date	SSN/TIN	%
Mailing address	Relationship to Insured	Telephone #	
Contingent Beneficiary full legal name	Date of birth/trust date	SSN/TIN	%
Mailing address	Relationship to Insured	Telephone #	
Contingent Beneficiary full legal name	Date of birth/trust date	SSN/TIN	%
Mailing address	Relationship to Insured	Telephone #	

If a Contingent Beneficiary is being named, please complete the signature section below.

I understand that this beneficiary designation must be recorded by the Administrator to be in effect, but when recorded, will take effect as of the date I signed this request. I also understand that the Administrator will not record any beneficiary designation received after the date of death of the Primary Insured on the above numbered certificate/policy. I further understand and agree that any payment made prior to the receipt of this beneficiary designation will not be affected.

Signature of Primary Insured or Owner		Date
Signature of witness (cannot be Beneficiary)	Address of witness	Date

Recorded by the Company on _____ By _____ **This beneficiary designation will not become effective until recorded by the Company. **

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