TRANSAMERICA
Employee Benefits

Return Completed Forms to:
Transamerica Employee Benefits
PO Box 219
Cedar Rapids, IA 52406-0219
Phone: (888) 763-7474
Fax: (866) 945-8691

Beneficiary Designation Form

Policy Owner Name (Last, First, M.I.)		Social Security No.
Insured Name(s) (Last, First, M.I.)		Social Security No.(s)
Policy No.	Employer Name	SD No.

I elect to designate the beneficiary(ies) under the above numbered policy issued as follows:
Primary Beneficiary(ies): For multiple beneficiaries, payment will be made in equal shares unless otherwise noted below.

Full Name (as it should appear on company records)	%	Street Address	City/State/Zip	Relationship	Date of Birth/Date of Trust

Phone No. SSN(s)/TIN(s):

Contingent Beneficiary(ies): Receives proceeds only if all Primary Beneficiaries predecease the Insured. For multiple beneficiaries, payment will be made in equal shares unless otherwise noted.

Full Name (as it should appear on company records)	%	Street Address	City/State/Zip	Relationship	Date of Birth/Date of Trust

Phone No. SSN(s)/TIN(s):

It is understood and agreed that, unless otherwise directed, proceeds will be paid in accordance with the policy provisions.

I understand that this beneficiary designation will not become valid until the signed form is received by Transamerica Life Insurance Company at the address listed above. Further, I understand that if benefits have been assigned under this contract, the Assignee must also sign this form in order for the designation to become valid. I agree that this designation will replace any existing beneficiary designations on my contract, if applicable.
For residents of **California**: 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 loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signed in (City/State) _____ This _____ Day of (Month/Year) _____.

Current Policy Owner _____ Witness _____

Policy Owner Marital Status ☐ Married ☐ Single

Spouse (required in community property states.)* _____ Witness _____

Assignee (if applicable) _____ Witness _____

Instructions

Section 1 Enter policy owner name and social security number, insured name and serial number, and policy or certificate number, if applicable. Include the name of all Insured parties and Employer's name. Please provide us with the Salary Deduction case number (if available).

Section 2 If you are selecting multiple beneficiaries, be sure to include the percentage amount that you would like for each beneficiary to receive, otherwise payment will be made in equal shares. If the proposed beneficiary is a married woman, use her own given and maiden names and her husband's surname (e.g., "Mary Joan Smith Jones", not "Mrs. John J. Jones").

Section 3 The following signatures are required:

(a) Policy Owner (If there are 2 or more co-owners, the signatures of each co-owner are required)
*(b) Spouse of Policy Owner (*If Married, Spouse of Policy Owner must sign if residence is in one of the community property states of: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin.*)
(c) Assignee (If any)
(d) **EACH SIGNATURE MUST BE WITNESSED BY A DISINTERESTED PARTY**.

ALL SIGNATURES MUST BE WRITTEN IN INK AND WRITTEN EXACTLY AS THE NAME IS GIVEN IN THE POLICY OR ASSIGNMENT.

FOR ADMINISTRATIVE OFFICE USE ONLY

The above requested beneficiary designations are herby acknowledged and recorded on the books of the Company indicated above.
Date Recorded _____ By _____

* Spouse or equivalent, as defined by governing state law.