USAble Life℠

BENEFICIARY CHANGE FORM

DATE RECEIVED HOME OFFICE:

SUBMIT YOUR CLAIM
Complete all fields and return to USAble Life
Attention: Membership
Mail: P.O. Box 1650 | Little Rock | AR | 72203
Email: membership@usablelife.com
Fax: (501) 235-8419

CUSTOMER CARE
(800) 370-5856 Monday-Friday, 8 a.m. to 5 p.m. CST

INSTRUCTIONS

1. The signature of the insured and the policyowner (if other than the insured) is required.
2. This form must be completed, signed, and forwarded to your employer's home office.
3. Give full legal name of each beneficiary and the relationship to the insured.

SAMPLE BENEFICIARY DESIGNATIONS

- **UNNAMED CHILDREN AS BENEFICIARIES**
  The legal, natural, or adopted child or children of the insured
- **PARTNERSHIP AS BENEFICIARY**
  Doe & Company
  100 North Main, Anytown, USA
  a partnership composed of John H. Doe and Richard A. Doe
- **CORPORATION AS BENEFICIARY**
  Doe & Company
  100 North Main, Anytown, USA
  a corporation organized under the laws of the state of Arkansas
- **TRUST AS BENEFICIARY**
  John H. Doe, Trustee under Trust Agreement
  Date (month, day, year):
- **CHARITY**
  American Cancer Society
  234 Main, Anytown, USA

INSURED/POLICYHOLDER INFORMATION

(for individual life policies only, if the policyholder is different from the insured, the policyholder must *complete this form)*

Insured Name (last, first, middle)	Date of Birth
Address (street, city, state, and ZIP)	
Telephone No.	Social Security No.
Employer Name (if applicable) Business Health Trust	
Policyholder Name (last, first, middle) *(if other than the insured)*	

POLICY INFORMATION

Policy No. 50054849	Type of Policy/Certificate GTL / VGTL / LTD
Policy No.	Type of Policy/Certificate
Policy No.	Type of Policy/Certificate

23L-USAL-0600

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PRIMARY BENEFICIARY(IES) (will receive proceeds if living at the time of death of the insured)	
I hereby designate the following primary beneficiary(ies) under the following coverage(s) and revoke the appointment of any existing beneficiary(ies)	
Beneficiary Full Name (last, first, middle)	Date of Birth
Address (street, city, state, and ZIP)	Social Security No.
Relationship to Insured	Percentage
Beneficiary Full Name (last, first, middle)	Date of Birth
Address (street, city, state, and ZIP)	Social Security No.
Relationship to Insured	Percentage
Beneficiary Full Name (last, first, middle)	Date of Birth
Address (street, city, state, and ZIP)	Social Security No.
Relationship to Insured	Percentage
Beneficiary Full Name (last, first, middle)	Date of Birth
Address (street, city, state, and ZIP)	Social Security No.
Relationship to Insured	Percentage
The total percentage for all beneficiaries listed above must equal 100%	**Total Percentage**
CONTINGENT BENEFICIARY(IES) (will receive proceeds if primary beneficiary(ies) are also deceased at the time of death of the insured)	
I hereby designate the following contingent beneficiary(ies) under the following coverage(s) and revoke the appointment of any existing beneficiary(ies)	
Beneficiary Full Name (last, first, middle)	Date of Birth
Address (street, city, state, and ZIP)	Social Security No.
Relationship to Insured	Percentage
Beneficiary Full Name (last, first, middle)	Date of Birth
Address (street, city, state, and ZIP)	Social Security No.
Relationship to Insured	Percentage
Beneficiary Full Name (last, first, middle)	Date of Birth
Address (street, city, state, and ZIP)	Social Security No.
Relationship to Insured	Percentage
Beneficiary Full Name (last, first, middle)	Date of Birth
Address (street, city, state, and ZIP)	Social Security No.
Relationship to Insured	Percentage
The total percentage for all beneficiaries listed above must equal 100%	**Total Percentage**
SIGNATURES	
Signature of Insured	Date
Signature of Policyholder *(if other than the insured)*	Date

USAble Life℠ is used with the consent of USAble Mutual Insurance Company.

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