

Complete each beneficiary class giving first name, middle initial, last name and relationship, as appropriate, of the beneficiary to the insured.

**The total for each beneficiary class must equal a total of 100%.**

**Primary beneficiary (s):** This is your first choice of the person (s) or entity to which the policy proceeds will be paid at the time of a claim. If more than one person is named, payment will be made in equal shares to the Primary beneficiary (s) who are living at the time proceeds are payable. If a percentage is indicated and a Primary beneficiary (s) is not alive at the time proceeds are payable, the percentage of that beneficiary's designated share will be divided equally among the surviving Primary beneficiary (s) unless otherwise indicated.

**Contingent beneficiary (s):** If the Primary Beneficiary (s) is deceased or the entity is not in existence at the time the policy becomes a claim, the death benefit is then paid to the Contingent beneficiary. If more than one person is named, payment will be made in equal shares to the Contingent beneficiary (s) who are living at the time proceeds are payable. If a percentage is indicated and a Contingent beneficiary (s) is not alive at the time proceeds are payable, the percentage of that beneficiary's designated share will be divided equally among the surviving Contingent beneficiary (s) unless otherwise indicated.

**The following are examples of the most common beneficiary designations:**

- Mary J. Doe (not Mrs. John Doe).
- Mary J. Doe, Wife, if living, otherwise to Joseph W. Doe, Son.
- Mary J. Doe, Wife, if living, otherwise to Jane Doe, Daughter, and Joseph W. Doe, Son, in equal shares, if they are both living, otherwise to whichever of them survive me.
- Estate of the Insured.
- Mary J. Doe 50%, Wife, Jane Doe 25%, Daughter, and Joseph W. Doe 25%, Son, in the event of one of their deaths their portion shall be divided equally among the remaining designations.

**A legal advisor should be consulted to discuss any questions or concerns on how a beneficiary designation should be written.**

# Ownership and Beneficiary Change Form

Ameritas Life Insurance Corp. ("Company") P.O. Box 81889, Lincoln, NE 68501 / 800-745-1112, Fax 402-467-7335

Policy Number: \_\_\_\_\_

Name of Insured/Annuitant: \_\_\_\_\_

This form operates to change only the beneficiaries for the following:

Check appropriate box(es)

Insured/Basic

Covered Insurance Rider – Self

Covered Insurance Rider – Other

Annuity Owner

Annuitant\* (Annuitant driven policies only)

\*Separate form required for each designation

<b>1. Designation of Beneficiary</b>	If a named beneficiary is a trust, complete a Trust Information form UN 2947 and submit it along with this form.	1021
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The undersigned policyowner hereby revokes any previous beneficiary designations with respect to any proceeds payable at the death of the Insured(s) designated above. **If an ownership and beneficiary change is being made simultaneously on this document, the current AND the new owner shall sign this form under Section 8 evidencing approval of the new designation of beneficiary in this section.**

As in all legalities, our records are only as valid as the information known to us and are subject to any outstanding or future legal proceedings such as; divorce or bankruptcy.

Primary beneficiary: Receives any proceeds payable at the insured's death

- The policy's death benefit will be paid to multiple beneficiaries in equal shares unless otherwise indicated.
- If additional space is needed, please write "See Attached" on this form and attach an additional page. Please sign and date this form as well as the additional pages(s).

Primary Full Name(s)	%	Address: Street City / State / ZIP	Relationship to Insured	Date of Birth or Date of Trust	SSN/TIN

Total: 100%

Contingent Full Name(s)	%	Address: Street City / State / ZIP	Relationship to Insured	Date of Birth or Date of Trust	SSN/TIN

Total: 100%

Policy Number:	Name of Insured/Annuitant:
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<b>2. Change of Ownership</b>	If changing Ownership to a trust, complete a Trust Information form UN 2947 and submit it along with this form.	1063
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U.S. individuals or entities **must** complete IRS Form W-9.  
Non U.S. individuals must complete the IRS Form W-8BEN; Non U.S. entities must complete the appropriate IRS Form W-8 series.  
**Complete the Billing Change section below.**

**Individual / Trust / Corporation Owners**

(1) Name of New Owner \_\_\_\_\_ SSN/TIN \_\_\_\_\_  
Address \_\_\_\_\_ Date of Birth \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

(2) Name of New Owner \_\_\_\_\_ SSN/TIN \_\_\_\_\_  
Address \_\_\_\_\_ Date of Birth \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

The undersigned assigns all policy rights, privileges and interest in the Policy to the new owner(s) (for multiple owners — AS JOINT TENANTS WITH RIGHT OF SURVIVORSHIP AND NOT AS TENANTS IN COMMON). This change of ownership is subject to all liens which the Company may have against the Policy. This change of ownership is absolute and no rights or interest are reserved to the undersigned (current owner).

**NOTE: If an ownership and beneficiary change is being made simultaneously on this document, the current owner AND the new owner shall sign this form evidencing approval of the new designation of beneficiary made.**

**Billing Change** NOTE: Premiums under this policy are to be paid by and premium notices, if any, will be sent to the new owner.

Use Existing Bank draft account  
 Use New Bank information (Complete EFT form UN 2178)  
 Direct Paper Bill  
Premium Frequency Change:  Annual  Semiannual  Quarterly  Monthly  List Bill

**Designation of Successor Ownership** Not Applicable for Annuity Contracts.

The owner of the policy shall be the owner during his/her lifetime. After the death of the owner, the ownership transfers to:  
Name \_\_\_\_\_ Relationship to Insured \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SSN / TIN \_\_\_\_\_  
If not living, or upon death of such successor owner, then the insured shall become the owner.

<b>3. Annuitant Change</b>	<input type="checkbox"/> Annuitant <input type="checkbox"/> Contingent Annuitant	1063
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Change Annuitant to \_\_\_\_\_ SSN \_\_\_\_\_  
Address \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Reason for this change \_\_\_\_\_

Policy Number:	Name of Insured/Annuitant:
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<b>4. Change Annuity Maturity Date</b>	1066
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To the first day of: Month \_\_\_\_\_ Year \_\_\_\_\_

<b>5. Premium Payor Change</b>	1067
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Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Country \_\_\_\_\_

Email \_\_\_\_\_

Relationship to Policy:  Insured  Owner  Payor  Assignee

Premium Frequency Change\*:  Annual  Semiannual  Quarterly

\*Electronic Fund Transfer is available. Please contact the Service Center or obtain form on-line.

<b>6. Duplicate Policy or Policy Certificate</b>	1104
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I certify that I have been unable to find the above described policy and I further certify that the policy is not assigned or pledged. I request the issuance of a duplicate policy, or certificate of insurance should duplicate policy forms not be available. I agree that (A) upon the issuance of a duplicate policy or certificate, the original policy shall be null and void, and (B) if the original policy is found, it will be immediately returned to the company. I agree to hold the company harmless from any claim or expense under the original policy.

**Request a Policy Certificate**

**Request a duplicate policy**

<b>7. Name Change</b>	<input type="checkbox"/> Insured / Annuitant <input type="checkbox"/> Owner <input type="checkbox"/> Payor <input type="checkbox"/> Assignee <input type="checkbox"/> Beneficiary	1064
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From \_\_\_\_\_ To \_\_\_\_\_  
First Middle Last

Reason \_\_\_\_\_

NOTE: If the reason for the name change is other than marriage, a certified copy of the court order is required.

Policy Number:	Name of Insured/Annuitant:
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**8. Declarations and Signatures** Form will be returned if this section is incomplete.

**NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an Insurer, submits an application or files a claim or other document containing a false or deceptive statement is guilty of insurance fraud.**

The undersigned hereby declares that:

- (1) I own the above policy and request the actions indicated, knowing community property law may require spouse consent; and
- (2) No bankruptcy proceedings are now pending against the owner.

**Community Property States:** The following are community property states and we request a spouse's signature (on Other Required Signature line) to process your chosen service request: California, Washington, Arizona, Nevada, New Mexico, Idaho, Wisconsin, Texas and Louisiana.

Date: \_\_\_\_\_  
                     Month                    Day                    Year

**X** \_\_\_\_\_  
 Signature of Current Owner

**X** \_\_\_\_\_  
 Signature of Current Joint Owner

\_\_\_\_\_  
 Print or Type Name of Current Owner

\_\_\_\_\_  
 Print or Type Name of Current Joint Owner

**X** \_\_\_\_\_  
 Signature of New Owner

**X** \_\_\_\_\_  
 Other Required Signature

\_\_\_\_\_  
 Print or Type Name of New Owner

\_\_\_\_\_  
 Print or Type Other Required Name

**IF BUSINESS OWNED:** Please check appropriate box:  Individual/Sole Proprietor  Corporation  Partnership  Trustee

\_\_\_\_\_  
 Business Name

**X** \_\_\_\_\_  
 Signature of Officer/Partner/Trustee

\_\_\_\_\_  
 Print or Type Officer/Partner/Trustee

**X** \_\_\_\_\_  
 Witness Signature (only required in MA)

\_\_\_\_\_  
 Date

\*Signature of the policy owner in MA must be witnessed by someone over the age of 18, not related to the policy owner(s), and not a named beneficiary.

Definitions

Trustor(s)/Grantor(s)/Settlor(s): The individual(s) who creates a trust and who gives (transfers) property to the trust.

Trustee(s): The individual(s) and/or institution(s) named by the trustor(s)/grantor(s)/settlor(s) to act on behalf of the trust according to the terms of the trust document.

Policy Number: \_\_\_\_\_

Name of Insured/Annuitant: \_\_\_\_\_

Trust is:  Owner  Beneficiary

1. Trust Information

This section asks for specific information that must be obtained from the Trust document. You must complete every line.

In consideration of the Company opening and/or maintaining one or more policies for the Trust named below, we the undersigned, Trustees, represent and verify as follows:

Full Name of the Trust			
Date of the Trust	Tax Identification Number used for the Trust		
Name(s) of the Trustor(s)/Grantor(s)/Settlor(s)			
Trust Address	City	State	ZIP

Please indicate the type of investments permitted within the powers of the Trust.

I/We represent and verify that I/We have power under the Trust and applicable law to enter into transactions, both purchases and sales, of the types specified below: Please indicate the products permitted within the powers of the Trust. (check all applicable products)

Life Insurance  Annuities  Other \_\_\_\_\_

The Trustee(s) may act:  Singly Must act:  Jointly  Other (explain): \_\_\_\_\_

2. Change of Trustee(s)

Is this form being completed to change the Trustee only?  Yes  No

If yes, one of the following is required: the previous Trustee's signature, a resignation letter from the previous Trustee, a copy of the death certificate (if previous Trustee is deceased) or a physician's statement if the previous trustee is incapacitated.

New Trustee #1 _____ Print the name of the new Trustee	New Trustee #2 _____ Print the name of the new Trustee
New Trustee #3 _____ Print the name of the new Trustee	New Trustee #4 _____ Print the name of the new Trustee

3. Representations and Verifications

I/We confirm that the Trust referred to in this document was properly executed and remains in-force as of the date this form is signed.

I/We represent and verify that the proposed transactions are within the powers of the Trust Agreement, and I/we am/are authorized as Trustee(s) of the Trust to conduct this transaction.

I/We represent(s) and verify to the Company that I/We constitute all of the authorized Trustee(s) of the Trust. The Company will not be required to inquire into the terms of the Trust Agreement and will not be charged with knowledge of the terms of the Trust Agreement. Trustee(s) has (have) the authority to sell, assign, exchange or alter any of the life insurance or annuity policies listed above. The Company is not obligated to inquire into any action taken by Trustee(s). The Company is released from any liability for actions taken in reliance upon this Form, and any change to the information on this Form must be made in writing. Any change will not be binding on the Company until received by the Company's offices. I/We agree to promptly inform the Company in writing, of any amendment to the Trust, any change in the composition of the Trustee(s), or any other event which could materially alter the Trust.

**Representations and Verifications** *(continued)*

If this form is a change of Trustee(s) the undersigned Trustee(s) represent and verify that the replacement Trustee(s) has (have) the same rights and powers as the previous Trustee(s) and that the replacement Trustee(s) is (are) fully qualified to act for the Trust according to the terms of the Trust.

As Trustee(s) of the aforementioned Trust, I (we) certify under penalty of perjury that the stated tax identification number in Section 2 is the correct tax identification number for the Trust.

I/We, the Trustee(s), jointly and severally indemnify the Company and hold the Company harmless from any liability for effecting any policy transactions pursuant to instructions given by any of the Trustee(s) listed below. It is understood and agreed that the Company shall not be responsible for the application or disposition of the proceeds by the Trustee(s) and the payment of the proceeds to the Trustee(s) shall fully and finally discharge the Company from all liability under the Policy(ies).

I/We have received and understand the terms of this document and have not relied on any representation or advice by the Company or its representatives regarding the legal or tax effects of this Trust Information Form.

The Company is authorized to accept instructions, including policy and distribution privileges, from those individual or entities listed below. I/We hereby represent, verify and attest UNDER PENALTY OF PERJURY that the undersigned are the Trustees authorized to conduct this transaction.

Date: \_\_\_\_\_  
                    Month                    Day                    Year

**X** \_\_\_\_\_  
Signature of Trustee

\_\_\_\_\_  
Print or Type Name of Trustee

**X** \_\_\_\_\_  
Signature of Trustee

\_\_\_\_\_  
Print or Type Name of Trustee

**X** \_\_\_\_\_  
Signature of New Trustee

\_\_\_\_\_  
Print or Type Name of New Trustee

**X** \_\_\_\_\_  
Signature of New Trustee

\_\_\_\_\_  
Print or Type Name of New Trustee

**X** \_\_\_\_\_  
Signature of Trustee

\_\_\_\_\_  
Print or Type Name of Trustee

**X** \_\_\_\_\_  
Signature of Trustee

\_\_\_\_\_  
Print or Type Name of Trustee

**X** \_\_\_\_\_  
Signature of New Trustee

\_\_\_\_\_  
Print or Type Name of New Trustee

**X** \_\_\_\_\_  
Signature of New Trustee

\_\_\_\_\_  
Print or Type Name of New Trustee

Federal law requires all financial institutions, including Insurance Companies, to obtain, verify, and record information that identifies each person who opens an account. This may include name, address, date of birth, and other information that will allow the Company to identify you. This will assist them in ensuring that your information is secure.

**We recommend you seek the advice of your tax and/or legal counsel with any questions you may have concerning your Trust.**

The Company reserves the right to request, when deemed necessary, a copy of the Trust Document and other documentation in addition to this executed form.