

PLEASE PRINT  
OR TYPE



# Alfa Life Insurance Corporation

## Change of Beneficiary

**NO CORRECTIONS OR ERASURES WILL BE ACCEPTED.**

**DO NOT SUBMIT POLICY FOR THESE CHANGES**

Service Center #	Policy Number	Name of Insured

Cancel all previous beneficiary designations and settlement options selected under the above numbered policy and change the beneficiary of the policy as designated below, with right of revocation.

**PRIMARY BENEFICIARY: (Must be listed, even if remains same)**

Full Name	Relationship To Insured

   **ESTATE OF INSURED**  
   **TRUST AGREEMENT:**

(Attach copy of the page in trust agreement showing date and name of trust)	Name of Trust	Name of Trustee
	Tax ID# of Trust	

**CONTINGENT BENEFICIARY:**

Full Name	Relationship To Insured

   **ESTATE OF INSURED**  
   **TRUST AGREEMENT:**

(Attach copy of the page in trust agreement showing date and name of trust)	Name of Trust	Name of Trustee
	Tax ID# of Trust	

It is agreed that these changes shall be an amendment to and form a part of the original application and policy. It is also agreed that THE ABOVE CHANGES SHALL BE EFFECTIVE ONLY WHEN RECORDED BY THE COMPANY AT ITS HOME OFFICE, BUT WHEN SO RECORDED SHALL TAKE EFFECT AS OF THE DATE SIGNED BY THE OWNER.

_____	_____	_____
Date	Witness	Signature of Policyowner

THE UNDERSIGNED AGREES TO THE ABOVE CHANGES

_____	_____
Signature of Assignee (if any)	Signature of Irrevocable Beneficiary (if any)

THIS SPACE IS FOR HOME OFFICE USE ONLY

**Alfa Life Insurance Corporation**

By \_\_\_\_\_  
Officer of the Company

\_\_\_\_\_  
Date Recorded

