

# Application for Change of Beneficiary

Mutual of Omaha Insurance Company and Insurance Affiliates\*  
Mutual of Omaha Plaza  
Omaha, NE 68175



**UNITED OF OMAHA LIFE  
INSURANCE COMPANY**  
A MUTUAL of OMAHA COMPANY

\*United of Omaha Life Insurance Company ▪ United World Life Insurance Company ▪ Omaha Insurance Company

## Instructions for Completing the Change of Beneficiary Form

**The Change of Beneficiary Form is attached.** Examples of wording that can be used to designate a beneficiary on this Form are set forth below. If the policy proceeds are to be paid other than in a single sum, do not use this form and contact United of Omaha Life Insurance Company for further instructions.

Type of Beneficiary	Sample Wording
1. Single Named Person .....	"Jane Doe, wife"
2. Two or more named persons in equal shares .....	"John Doe, father, and Mary Doe, mother, in equal shares"
3. Two or more named persons in unequal shares .....	"40 percent to John Doe, father, and 60 percent to Mary Doe, mother" – <b>[do not use dollar amounts]</b>
4. Unnamed children of a specified marriage .....	"Children of the marriage of the insured
(excluding children by a previous marriage, foster children and stepchildren)	and Jane Doe"
5. Trustee under Last Will and Testament of Insured .....	"Trustee, or successor in Trust, named in the Last Will and Testament of the Insured; provided, however, that if no Trustee is appointed within one year of the Insured's death, payment shall be made to the Insured's estate"
6. Other Trust Arrangements .....	"Professional Trust Company, Trustee, or its successor in Trust, under Trust Agreement dated Jan. 1, 1982"
7. Corporation .....	"XYZ, Inc., a New York corporation"
8. Partnership .....	"ABC Company, a partnership"
9. Executor or administrator .....	"Insured's estate"

## Instructions for Signing the Change of Beneficiary Form

**Who Must Sign:** The Change of Beneficiary Form must be signed by the person or persons who, under the terms of the policy, have the right to change the beneficiary. If the previous beneficiary was designated as an irrevocable beneficiary, that irrevocable beneficiary must also sign.

**How to Sign:** Your request cannot be processed without the correct signature(s), date and applicable documentation. If signed by:

- (a) a **corporation**, an authorized officer must sign. Be sure to include the title of the officer and the full corporate name.
  - if **president** – no additional requirements
  - if **any other officer** – provide a Board of Directors resolution authorizing the change
- (b) a **partnership** with at least two general partners, two authorized general partners must sign with the title "general partner" after each name (if only one use "sole general partner") and include the full name of the partnership. Also submit a copy of the pages of the partnership agreement showing the authorized partner(s) names and signature(s).
- (c) a **limited liability company**, the individual(s) authorized to act must sign. Be sure to include the title of the individual and the company name. Also provide the document (e.g., operating agreement or articles of organization) that defines who is authorized to act for the company.
- (d) a **holder of power of attorney** must provide a copy of the power of attorney and include, following his or her signature, the words "Attorney-in-fact for (owner's name)."

If signed with an "X" mark or in foreign characters, the signature must be witnessed by two witnesses and the address of each witness must be given.

Changing a beneficiary will not change the ownership of the policy. The interest of any beneficiary will be subject to the interest of any collateral assignee under a collateral assignment on record with the company.

## Change of Beneficiary

Insured Name \_\_\_\_\_

Social Security Number \_\_\_\_\_

Insured Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

Policyowner's Name \_\_\_\_\_

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

### IMPORTANT!

1. Proceeds payable must be expressed as percentages rather than dollar amounts.
2. Please use full given names. Examples: "Mary E. Doe" rather than "Mrs. John E. Doe."
3. Forms cannot be accepted which contain corrections or erasures.
4. If more space is needed for additional beneficiaries, please attach a separate sheet of paper or copy of this form.
5. Complete, sign and return this form for each Policy and/or Policy Rider for which you are requesting a change.

Mail completed form to: Mutual of Omaha  
Mutual of Omaha Plaza  
Omaha, NE 68175

Fax to: ATTN: Policyowner Services  
402-997-1906

### Primary Beneficiary(ies)

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Social Security Number \_\_\_\_\_ Relationship \_\_\_\_\_ Benefit Percent \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Social Security Number \_\_\_\_\_ Relationship \_\_\_\_\_ Benefit Percent \_\_\_\_\_

- Irrevocable Primary Beneficiary(ies):** If this Box is checked, the Policy will be endorsed to show that the Primary Beneficiary(ies) named above is/are irrevocable. Future changes to the Policy and/or rider(s), including a change of beneficiary(ies), may not be made by the Policyowner(s)/Trustee(s) without the consent of the Irrevocable Primary Beneficiary(ies) shown above.

### Contingent Beneficiary(ies)

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Social Security Number \_\_\_\_\_ Relationship \_\_\_\_\_ Benefit Percent \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Social Security Number \_\_\_\_\_ Relationship \_\_\_\_\_ Benefit Percent \_\_\_\_\_

Please see next page

Unless otherwise shown above: (a) payment will be shared equally by all Primary Beneficiaries who survive the Insured; if none, by all Contingent Beneficiaries who survive the Insured; (b) the right to change the beneficiary is reserved unless otherwise stated; (c) the word "child" or "children" shall include legally adopted children.

No changes are binding until received and recorded by the company at the home office. We will record the change(s) and send a confirmation.

The company reserves the right to declare this form void and of no effect if it is incomplete or completed in an unsatisfactory manner.

As Policyowner, I hereby revoke any previous Beneficiary designation. I request that upon the death of the Insured named above all proceeds of the Policy and/or rider(s) covering the Insured be paid to the beneficiary(ies) as shown above.

**X** \_\_\_\_\_  
**Signature of Policyowner** **Date**  
\*If the Policyowner is a corporation or partnership, include documentation indicating authorized signature(s).

**X** \_\_\_\_\_  
**Signature of all current Irrevocable Primary Beneficiary(ies)**  
**(if applicable)**

**X** \_\_\_\_\_  
**Signature of Joint Policyowner (if applicable)** **Date**  
\*If the Policyowner is a corporation or partnership, include documentation indicating authorized signature(s).

**X** \_\_\_\_\_  
**Signature of all current Irrevocable Primary Beneficiary(ies)**  
**(if applicable)**

**For Massachusetts residents only:**

State law requires that a disinterested adult, who is not a party to the Policy, witness any request to change the beneficiary arrangement.

**X** \_\_\_\_\_  
Witness' Signature (Massachusetts only)