

1. Policy Owner and Insured Information

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

2. Name Changes

Change name of Insured Owner Payor Beneficiary
 From _____ To _____
 Reason for Change Marriage*** Divorce Correction Other _____

3. Policy Owner Changes

Record the following Transfer of Ownership** Change Owner Address

New Owner Name _____ Social Security No. _____
 Address _____ Daytime Phone No. _____
 _____ Evening Phone No. _____

All right, title and interest in this policy are transferred to the new owner. This transfer is subject to any policy loans and collateral assignments. The change of ownership does not change the beneficiary. Any existing owner's designee or contingent owner is revoked.

4. Billing Changes

New Premium Mode Pre-Authorized checking Direct Bill
 New Premium Frequency Monthly Quarterly After Tax Other _____
 Change Planned Periodic Payment To \$ _____

5. Reduction In Benefits

Reduce face amount to \$ _____ (may be subject to company imposed surrender penalties)
 Change Planned Periodic Premium for reduced face amount (see #4)
 Cancel Accidental Death Rider Cancel Waiver Provision Cancel Children's Term Rider
 Other _____

6. Beneficiary Changes

I hereby revoke any and all prior beneficiary designations and existing settlement agreements, if any, and elect to change the beneficiary(ies) under the above numbered policy 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

Phone No.: _____ SSN/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

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

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

7. Signatures

I/We understand and agree that my/our signature(s) below shall apply to each request which has been checked on this form and further agree that no request will become effective which is not checked. I/We agree that these changes shall become part of the policy. I/We request that any provisions in said policy requiring its endorsement to effect the change requested be waived and that these changes be effective upon completion and execution of this form and approval hereof by the company at its Administrative Office. I/We certify that no insolvency or bankruptcy proceedings are now pending against me/us.

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

Current Policy Owner (sign) _____ Witness _____
Policy Owner Marital Status Married Single (sign) _____

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

Assignee (if applicable) _____ Witness _____

FOR ADMINISTRATIVE OFFICE USE ONLY

The above requested policy changes are hereby acknowledged and recorded on the books of the Company indicated above. Endorsement of such change on said policy is hereby waived.

Date Recorded _____ By _____

Instructions

Item #1: Complete this section for all requests. Enter policy owner name and social security number, insured name and serial number, and policy or certificate number. Always include the name of all Insured parties and Employer's name. Please provide us with the Salary Deduction case number (if available).

Item #2: Complete this section only if you are requesting a name change. (Not used to transfer ownership)

Item #3: Complete this section only if you are requesting to transfer ownership or change address of current owner. Be sure to provide all information as requested.

****This form can only be used to transfer ownership of individually owned policies. For all other policies you must complete Form TEB-Transfer.**

Item #4: Complete this section only if you are requesting to change your billing mode or frequency. For automatic bank draft, you will need to complete form **TEB-BankDraft**.

Item #5: Complete this section only if you are requesting to reduce your benefits/coverage.

Item #6: Complete this section only if you are requesting to change your designated beneficiaries. 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").

Item #7: Complete this section for all requests. 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.** (A disinterested party is anyone of age who is not the insured or the beneficiary.)

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

General Notice

In the event your policy/certificate is a Modified Endowment Contract (MEC), amounts received (including loans, assignments and/or pledges) prior to the death of the Insured may be fully taxable, and before the owner is age 59-1/2, subject to a 10% tax penalty. Under the Technical and Miscellaneous Revenue Act of 1988 (TAMRA), a life insurance contract becomes a MEC when actual premiums paid exceed a specified 7-pay premium limit or when certain changes are made to policy benefits.

Transamerica Employee Benefits does not offer tax or legal advice. Because tax laws are subject to change and different interpretations, we recommend that you seek counsel from a qualified tax advisor.

Return Completed Forms to:

Aon Risk Solutions – Union Benefits

Aon – MSC# 17862

P.O. Box 551343

Atlanta, GA 30355

EMAIL: Univers.Labor@aon.com

FAX: 847-953-1859