Homesteaders Life Company
P.O. Box 1756 • Des Moines, IA 50306-1756 • 800-477-3633

BENEFICIARY CHANGE FORM

1. POLICY/INSURED INFORMATION

Policy Number	First Name of Insured	Middle Initial	Last Name of Insured

Street Address, City, State, Zip Code

2. POLICY OWNER INFORMATION (complete only if different from insured)

First Name of Policy Owner	Middle Initial	Last Name of Policy Owner

Street Address, City, State, Zip Code

3. PRIMARY BENEFICIARY INFORMATION

- ***THIS DESIGNATION REVOKES ALL PREVIOUS PRIMARY BENEFICIARY DESIGNATIONS***
- ***DEATH BENEFITS WILL BE PAID EQUALLY AMONG DESIGNATED PRIMARY BENEFICIARIES***
- ***IF MORE THAN 2 PRIMARY BENEFICIARIES ARE NEEDED, PLEASE PROVIDE SAME INFORMATION FOR ADDITIONAL BENEFICIARIES ON THE BACK OF FORM***

First Name of Primary beneficiary	Middle Initial	Last Name of Primary beneficiary	Social Security # of beneficiary *

Relationship to Insured	Birthdate (mm/dd/yyyy)	Telephone #	Email Address of beneficiary

Street Address, City, State, Zip Code of Primary beneficiary

ADDITIONAL PRIMARY BENEFICIARY (OPTIONAL)

First Name additional Primary beneficiary	Middle Initial	Last Name of Primary beneficiary	Social Security # of beneficiary *

Relationship to Insured	Birthdate (mm/dd/yyyy)	Telephone #	Email Address of beneficiary

Street Address, City, State, Zip Code of Primary beneficiary

4. CONTINGENT BENEFICIARY INFORMATION (OPTIONAL)

- ***CONTINGENT BENEFICIARY IS ENTITLED TO DEATH BENEFITS ONLY IF NO PRIMARY BENEFICIARY IS LIVING AT THE TIME OF INSURED'S DEATH***
- ***THIS DESIGNATION REVOKES ALL PREVIOUS CONTINGENT BENEFICIARY DESIGNATIONS***
- ***DEATH BENEFITS WILL BE PAID EQUALLY AMONG DESIGNATED CONTINGENT BENEFICIARIES***
- ***IF MORE THAN 1 CONTINGENT BENEFICIARY IS NEEDED, PLEASE PROVIDE SAME INFORMATION FOR ADDITIONAL BENEFICIARIES ON THE BACK OF FORM***

First Name of Contingent Beneficiary	Middle Initial	Last Name	Social Security # *

Relationship to Insured	Birthdate (mm/dd/yyyy)	Telephone #	Email Address

Street Address, City, State, Zip Code of Contingent beneficiary

5. POLICY OWNER SIGNATURE	Date	Policy Owner Phone #

6. WITNESS SIGNATURE **

* Either SSN **OR** DOB required for each beneficiary

** Required if original application was electronic. Witness must be a disinterested third party and may not be the insured, owner, agent, previous or new beneficiary. Notary not required.

California Residents Only: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.