

**ASSURITY® LIFE INSURANCE COMPANY**Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 869-0355 • FAX (402) 437-4658**Designation of
TRUST BENEFICIARY***First, Middle, Last*

Insured's Name _____ Policy Number _____

Owner's Home/Cell Phone (____) _____ / (____) _____ Owner's Business Phone (____) _____

The undersigned policyowner hereby revokes any previous beneficiary designation and any optional mode of settlement with respect to any death benefit proceeds payable at the death of the insured. Any such proceeds shall be paid as shown below.

- First, funds are paid to all primary beneficiaries who are living/existing when the insured dies.
- If no primary beneficiaries are living/existing when the insured dies, then funds are paid to contingent beneficiaries who are living/existing.
- If no beneficiary is living/existing when the insured dies, then funds are paid to the owner or owner's estate.
- When more than one living/existing beneficiary is in a class, funds are paid in equal shares unless otherwise designated.
- Payment to a trust as directed by this Beneficiary Designation ends the Company's responsibility in full. If a trust is beneficiary but does not exist when the insured dies, or no trustee qualifies or makes claim within six (6) months after the insured dies, or the Company receives proof that no trustee will qualify or make claim, then the funds shall be paid as if that trust ceased to exist before the insured died.
- An irrevocable beneficiary must consent to a change of beneficiary, but has no other rights.
- This beneficiary designation voids all earlier primary or contingent beneficiary designations.

1. Primary Beneficiary(ies) –
 Living Trust _____
Name of Trust
Dated ____/____/____ of _____ of
(MM/DD/YYYY) *Name of Trustee*_____, Trustee or Successor.
Full Address of Trustee *City* *State* *Zip code +4*
 Testamentary Trust created by that instrument admitted to probate as the Last Will and Testament of the insured. The funds shall be paid to the trustee, or successor, named in that trust.

 Individual(s) _____
Full Name *Date of Birth (MM/DD/YYYY)* *Social Security No.*

Full Address *City* *State* *Zip code +4* *Relationship to Insured*
2. Contingent Beneficiary(ies) –
 Living Trust _____
Name of Trust
Dated ____/____/____ of _____ of
(MM/DD/YYYY) *Name of Trustee*_____, Trustee or Successor.
Full Address of Trustee *City* *State* *Zip code +4*
 Testamentary Trust created by that instrument admitted to probate as the Last Will and Testament of the insured. The funds shall be paid to the trustee, or successor, named in that trust.

 Individual(s) _____
Full Name *Date of Birth (MM/DD/YYYY)* *Social Security No.*

Full Address *City* *State* *Zip code +4* *Relationship to Insured*

Date (MM/DD/YYYY)

Signature of Owner

Signature of Witness (A non-related person with no financial interest in the policy.)

Signature of Joint Owner

The Insurer has acknowledged and recorded the above designation.

Date (MM/DD/YYYY) *Authorized Signature* *Title*
