TRANSAMERICA®
Employee Benefits

Return Completed Forms to:
AON Union Benefits Customer Service Dept.
1060 Maitland Center Commons Suite 210, Maitland, FL 32751
Phone: (866) 697-8897 Fax: (847) 953-1859
Email Address: Univers.Labor@aon.com

Beneficiary Designation Form

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

I elect to designate the beneficiary(ies) under the above numbered policy issued 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

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

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

I understand that this beneficiary designation will not become valid until the signed form is received by Transamerica Life Insurance Company at the address listed above. Further, I understand that if benefits have been assigned under this contract, the Assignee must also sign this form in order for the designation to become valid. I agree that this designation will replace any existing beneficiary designations on my contract, if applicable.

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

Current Policy Owner _____ Witness _____
Policy Owner Marital Status ☐ Married ☐ Single
Spouse (required in community property states.)* _____ Witness _____

Assignee (if applicable) _____ Witness _____

Instructions

Section 1 Enter policy owner name and social security number, insured name and serial number, and policy or certificate number, if applicable. Include the name of all Insured parties and Employer's name. Please provide us with the Salary Deduction case number (if available).

Section 2 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").

Section 3 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**.
ALL SIGNATURES MUST BE WRITTEN IN INK AND WRITTEN EXACTLY AS THE NAME IS GIVEN IN THE POLICY OR ASSIGNMENT.

FOR ADMINISTRATIVE OFFICE USE ONLY

The above requested beneficiary designations are herby acknowledged and recorded on the books of the Company indicated above.
Date Recorded _____ By _____

TEB-Beneficiary-091211

* Spouse or equivalent, as defined by governing state law.