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

Insured's Name ______ (First / Middle / Last) 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 all primary beneficiaries are not 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.

1. Primary Beneficiary(ies) –

☐ **Living Trust** ______ *Name of Trust*

Dated / / *(MM/DD/YYYY)* ______ *Name of Trustee* of

______ , 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 / / *(MM/DD/YYYY)* ______ *Name of Trustee* of

______ , 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 Ownership Transfer.

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