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| <input type="checkbox"/> Acacia Life Insurance Company P.O. Box 81889, Lincoln, NE 68501 800-745-1112, Fax 402-467-7335 (Client Service Department) | <input type="checkbox"/> Ameritas Life Insurance Corp. P.O. Box 81889, Lincoln, NE 68501 800-745-1112, Fax 402-467-7335 | <input type="checkbox"/> The Union Central Life Insurance Company P.O. Box 40888, Cincinnati, OH 45240 800-319-6901, Fax 513-595-2218 |
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Policyowner's Change and Service Request

THE UNDERSIGNED REQUESTS and DIRECTS the Company to CHANGE POLICY NUMBER _____
on the life of _____.

This form operates to change only the beneficiaries for the following: Check appropriate box(es)

- | | |
|--|--|
| <input type="checkbox"/> Insured/Basic | <input type="checkbox"/> Annuity Owner* |
| <input type="checkbox"/> Covered Insurance Rider – Self | <input type="checkbox"/> Annuitant* (Annuitant driven policies only) |
| <input type="checkbox"/> Covered Insurance Rider – Other | *Separate UN 3379A form required for each designation |

1. DESIGNATION OF BENEFICIARY

This form changes only the Primary Insured's Beneficiaries unless otherwise noted. As in all legalities, our records are only as valid as the information known to us and is subject to any outstanding or future legal proceedings such as; divorce or bankruptcy.

The undersigned policyowner hereby revokes any previous beneficiary designations with respect to any proceeds payable at the death of the Insured(s) designated above. **If an ownership and beneficiary change is being made simultaneously on this document, the new owner shall also sign this form under Section 9 evidencing approval of the new designation of beneficiary in this section.**

Multiple beneficiaries of the same class will be paid equally. If one or more beneficiaries of the same class predeceases the insured(s), that beneficiary's share shall be equally divided among the surviving beneficiaries of the same class unless the Special Provision is checked below. Any such proceeds shall be paid in one sum as follows (please check appropriate box and complete requested information):

PRIMARY

- (1) Full Name _____ SS# _____ Date of Birth _____
Address _____ Relationship _____
- (2) Full Name _____ SS# _____ Date of Birth _____
Address _____ Relationship _____
- (3) Full Name _____ SS# _____ Date of Birth _____
Address _____ Relationship _____
- (4) Full Name _____ SS# _____ Date of Birth _____
Address _____ Relationship _____

CONTINGENT

- (1) Full Name _____ SS# _____ Date of Birth _____
Address _____ Relationship _____
- (2) Full Name _____ SS# _____ Date of Birth _____
Address _____ Relationship _____
- (3) Full Name _____ SS# _____ Date of Birth _____
Address _____ Relationship _____
- (4) Full Name _____ SS# _____ Date of Birth _____
Address _____ Relationship _____

Special Provision

- PER STIRPES:** If a beneficiary of the Insured(s) predeceases the Insured(s) leaving children who survive the Insured, the share such deceased beneficiary would have received had such beneficiary survived the Insured(s) shall be paid in equal shares to the then surviving children of such deceased beneficiary. If no such children survive, then that beneficiary's share shall be equally divided among the surviving beneficiaries.

| | |
|----------------|----------|
| Policy Number: | Insured: |
|----------------|----------|

2. CHANGE OF OWNERSHIP **New Owner must complete Section 8, Request for Taxpayer Identification Number.**

Individual / Trust / Corporation Owners
Trust Owners must also complete Trust Information Worksheet in Section 4

If new owner is an Irrevocable Trust, use form UN 518-T. Include a complete copy of the Trust.

(1) Name of New Owner _____ SSN / TIN _____
 Address _____ Date of Birth _____

(2) Name of New Owner _____ SSN / TIN _____
 Address _____ Date of Birth _____

(3) Name of New Owner _____ SSN / TIN _____
 Address _____ Date of Birth _____

The undersigned assigns all policy rights, privileges and interest in the Policy to the new owner(s) (for multiple owners — AS JOINT TENANTS WITH RIGHT OF SURVIVORSHIP AND NOT AS TENANTS IN COMMON). This change of ownership is subject to all liens which the Company may have against the Policy. This change of ownership is absolute and no rights or interest are reserved to the undersigned (current owner).

NOTE: If an ownership and beneficiary change is being made simultaneously on this document, the new owner shall also sign this form under Section 9 evidencing approval of the new designation of beneficiary made in Section 1.

DESIGNATION OF SUCCESSOR OWNERSHIP

The owner of the policy shall be the owner during his/her lifetime. After the death of the owner, the ownership transfers to:

Name _____ Relationship to Insured _____
 Date of Birth _____ SSN / TIN _____

If not living, or upon death of such successor owner, then the insured shall become the owner.

3. NAME CHANGE INSURED OWNER PAYOR ASSIGNEE BENEFICIARY

From _____ To _____
 Reason _____

NOTE: If the reason for the name change is other than marriage, a certified copy of the court order is required.

4. TRUST INFORMATION WORKSHEET

Full copy of Trust must accompany request. If Irrevocable Trust, use form UN 518-T; for other Trusts, complete this section.

GENERAL TRUST INFORMATION

Type of Trust: Revocable Trust Irrevocable Trust Tax Identification Number (TIN) _____
 Testamentary Trust: Under the Last Will and Testament of _____
 Execution Date of Will _____

NAME OF TRUST _____

Date Trust was established _____ State where Trust was established _____

Name of the Grantor(s) who established the Trust _____

Name(s) and address(es) of Trustee(s):

Trustee _____ Address _____

Trustee _____ Address _____

Successor Trustee(s) _____ Address _____

| | |
|----------------|----------|
| Policy Number: | Insured: |
|----------------|----------|

5. PREMIUM PAYOR CHANGE

Name _____

Address _____

City _____ State _____ ZIP _____ Country _____

Relationship to Policy: INSURED OWNER PAYOR ASSIGNEE OTHER Explain _____**6. DUPLICATE POLICY OR POLICY CERTIFICATE**

I certify that I have been unable to find the above described policy and I further certify that the policy is not assigned or pledged. I request the issuance of a duplicate policy, or certificate of insurance should duplicate policy forms not be available. I agree that (A) upon the issuance of a duplicate policy or certificate, the original policy shall be null and void, and (B) if the original policy is found, it will be immediately returned to the company. I agree to hold the company harmless from any claim or expense under the original policy.

7. RELEASE OF INTEREST / CREDITOR'S ASSIGNMENT

Dated _____ For value received, the undersigned assignee hereby releases all right, title and interest in this policy.

SECTION 7
SIGN
HERE →

Witness (Required) _____

Signature _____

8. REQUEST FOR TAXPAYER IDENTIFICATION NUMBER • W-9Name of **New** Policyowner (please print) _____

Enter taxpayer identification number. For most individual taxpayers, this is the Social Security Number.

I certify under penalty of perjury that: 1) the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); 2) I am not subject to backup withholding because: a) I am exempt from backup withholding, or b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or c) the IRS has notified me that I am no longer subject to backup withholding; and 3) I am a U.S. person (including a U.S. resident alien).

You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return. THE INTERNAL REVENUE SERVICE DOES NOT REQUIRE YOUR CONSENT TO ANY PROVISION OF THIS DOCUMENT OTHER THAN THE CERTIFICATIONS REQUIRED TO AVOID BACKUP WITHHOLDING.

SECTION 8
SIGN
HERE →

Witness (Required) _____

New Owner (sign if ownership change) _____

| | |
|----------------|----------|
| Policy Number: | Insured: |
|----------------|----------|

9. DECLARATIONS AND SIGNATURES

NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an Insurer, submits an application or files a claim or other document containing a false or deceptive statement is guilty of insurance fraud.

The undersigned hereby declares that:

- (1) I own the above policy and request the actions indicated, knowing community property law may require spouse consent; and
- (2) No bankruptcy proceedings are now pending against the owner.

IMPORTANT: Please note, if the policyowner is a resident of a community property state (AZ, CA, ID, LA, NV, NM, TX, WA, and WI), the policyowner’s spouse is required by that state to sign this form on the “Other Required Signature” line. The form will be returned if incomplete. If the policyowner has never been married, then please state “Not Married” on the “Other Required Signature” line. If the policyowner is divorced or the spouse is deceased, we will need verification of this for our records for future requests, i.e., certified copy of death certificate, certified copy of divorce decree.

Signed at _____ Date _____
City and State

Witness (Signature)

Current Owner’s Signature (Title if Applicable)

Witness (Signature)

New Owner’s Signature (Title if Applicable)

Witness (Signature)

Other Required Signature

IF BUSINESS OWNED: Please check appropriate box: Individual/Sole Proprietor Corporation Partnership Trustee

Business Name _____

Signature and Title _____ Date _____

(Signature MUST be that of an Officer, Partner, or Trustee of the company, other than the Insured)

Assignee’s Signature _____ Date _____

Recorded at Service Department on _____ By _____

Title _____