Additional Beneficiary Designations for Inforce Policies Form

American National / One Moody Plaza, Galveston, TX 77550-7947

Overnight Address Mail Processing Center, Attn: LIS 3257, 1949 E. Sunshine St., Springfield, MO 65899-0001 / **Phone** 1-800-899-6806

Mailing Address Mail Processing Center, P.O. Box 3257, Springfield, MO 65808-3257

* B E N E F *

1 Company Selection

- ☐ American National Insurance Company
- ☐ American National Life Insurance Company of Texas
- ☐ Garden State Life Insurance Company
- ☐ American National Life Insurance Company of New York
- ☐ Standard Life and Accident Insurance Company

2 Instructions

This is not a stand-alone form. It is only to supplement the Beneficiary Change Request Form.

- Completion of these forms replaces all previous Beneficiary designations.
- These forms must reflect ALL Beneficiaries, both Primary and Contingent, who should receive proceeds of the policy listed below.

3 Current Information

Insured's First Name _____ M.I. _____ Last Name _____ Policy Number _____

Owner's First Name _____ M.I. _____ Last Name _____ Date of Birth _____

Owner's Street Address _____ City _____ State _____ ZIP _____

E-mail Address _____ Telephone _____

4 Additional Primary Beneficiary Designations

▶ **NOTE:** Unless specified, Beneficiaries within the same class share equally. Allocations must add up to 100%. Fractional allocations will not be accepted (Example: 1/3). Complete as much information as possible for each beneficiary.

Use Full Legal Names

First Name | M.I. | Last Name | Gender ☐ Male ☐ Female | Allocation (Whole % Only)

Date of Birth | SSN/TIN | Relationship to Insured

Street Address | City | State | ZIP

E-mail Address | Telephone

First Name | M.I. | Last Name | Gender ☐ Male ☐ Female | Allocation (Whole % Only)

Date of Birth | SSN/TIN | Relationship to Insured

Street Address | City | State | ZIP

E-mail Address | Telephone

First Name | M.I. | Last Name | Gender ☐ Male ☐ Female | Allocation (Whole % Only)

Date of Birth | SSN/TIN | Relationship to Insured

Street Address | City | State | ZIP

E-mail Address | Telephone

5 Additional Contingent Beneficiary Designations

► **NOTE:** Unless specified, Beneficiaries within the same class share equally. Allocations must add up to 100%. Fractional allocations will not be accepted (Example: 1/3). Complete as much information as possible for each beneficiary.

Contingent Beneficiary(ies) will be paid only if no Primary Beneficiary(ies) survive the Insured.

Use Full Legal Names

First Name ______ M.I. ____ Last Name ______ Gender ☐ Male ☐ Female Allocation (Whole % Only) ______

Date of Birth ______ SSN/TIN ______ Relationship to Insured ______

Street Address ______ City ______ State ______ ZIP ______

E-mail Address ______ Telephone ______

First Name ______ M.I. ____ Last Name ______ Gender ☐ Male ☐ Female Allocation (Whole % Only) ______

Date of Birth ______ SSN/TIN ______ Relationship to Insured ______

Street Address ______ City ______ State ______ ZIP ______

E-mail Address ______ Telephone ______

First Name ______ M.I. ____ Last Name ______ Gender ☐ Male ☐ Female Allocation (Whole % Only) ______

Date of Birth ______ SSN/TIN ______ Relationship to Insured ______

Street Address ______ City ______ State ______ ZIP ______

E-mail Address ______ Telephone ______

6 Special Requests

______

______

7 State Specific Fraud Language

For California Residents:

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.

8 Acknowledgment and Signatures

Signature requirements:

- Each Owner must print their name, then sign and date the form to indicate approval of the change.
- If there is an Irrevocable Beneficiary or an Assignee, they must also print their name, then sign and date the form to indicate their approval of the change.
- Each signature requires a disinterested witness signature. A disinterested witness is an adult that is not being named Beneficiary and is not otherwise signing this form. (Required in MA only) The Agent's signature is recommended.
- If someone else is signing on behalf of an Owner, the full names of both the Owner and the Signer must be provided. Include copies of any documents proving legal authority, such as power of attorney, guardianship papers, etc.
- If the Owner is a legal entity: trust, business or on behalf of Owner as guardian or power of attorney, include any necessary documents needed for legal authorization.

I understand that by signing below, I am revoking all previous beneficiary designations, and the changes on this form will become effective on the date I sign this form.

Owner:

Print Owner's Full Name | **Title** (Required for Officer, Trustee or Power of Attorney)

x
Signature of Owner | **Date:** Month / Day / Year

Print Agent or Witness's Full Name (Required in MA ONLY)

x
Signature of Agent or Witness (Required in MA ONLY) | **Date:** Month / Day / Year

Joint Owner (If Applicable):

Print Joint Owner's Full Name | **Title** (Required for Officer, Trustee or Power of Attorney)

x
Signature of Joint Owner | **Date:** Month / Day / Year

Print Agent or Witness's Full Name (Required in MA ONLY)

x
Signature of Agent or Witness (Required in MA ONLY) | **Date:** Month / Day / Year

Irrevocable Beneficiary or Assignee (if applicable):

Print Irrevocable Beneficiary or Assignee's Full Name | **Title** (Required for Officer, Trustee or Power of Attorney)

x
Signature of Irrevocable Beneficiary or Assignee | **Date:** Month / Day / Year

Print Agent or Witness's Full Name (Required in MA ONLY)

x
Signature of Agent or Witness (Required in MA ONLY) | **Date:** Month / Day / Year

For Home/Administrative Office Endorsement Only

Agency Code 1- | CSSD Code 2- | City | State

Processor's First Name | M.I. | Last Name | Date

This request has been recorded at the Home/Administrative Office of American National or its affiliates.
Effective Date of Change