Lincoln Financial Group®

Life Client Solutions Contact Information
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The Lincoln National Life Insurance Company
Lincoln Life & Annuity Company of New York
First Penn-Pacific Life Insurance Company
(as in your contract and herein "the Company")

Beneficiary Change for Life Policy

General Information (Please type or print clearly.)

This section must be completed.

Policy/Certificate No.: _____

Issued by (the Company): _____

Insured Information

Full Legal Name *(First, Middle, Last)*: _____

Insured's Mailing Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Birth: _____

Daytime Telephone Number: _____ ☐ Check here if new address

Email Address: _____

Owner Information (If different from Insured. Submit more pages as necessary.)

Full Legal Name *(First, Middle, Last)*: _____

Owner's Mailing Address: _____

City: _____ State: _____ Zip: _____

Social Security Number / EIN*: _____ Date of Birth / Trust**: _____

Daytime Telephone Number: _____ ☐ Check here if new address

Email Address: _____

*The submission of a completed IRS Form W-9 may be required. Employer Identification Number for Trusts or Entities

**The date the trust was established

Instructions

Almost all beneficiary changes can be requested by using this form. However, if there is any question concerning the completion of the request or if a beneficiary designation is desired which cannot be requested on this form, contact your local representative or Agency which services your policy.

1. Complete a separate request for change of beneficiary for each policy to be changed, unless the owner and all information is the same for all policies.
2. A form which has been altered or on which there has been an erasure cannot be accepted unless the alteration or erasure is initialed by the policy owner(s).
3. This form is to be forwarded to the Company. A confirmation of the beneficiary change will be sent to you for your records.
4. This form is not to be used to elect an Optional Method of Settlement.
5. Irrevocable Beneficiaries: An irrevocable beneficiary is a designation that cannot be changed without the irrevocable beneficiary's written consent. It is also a designation that for any change (i.e. withdrawal, ownership change, etc.) to the policy/contract, we will require the irrevocable beneficiary to sign and date the request. If you are naming an irrevocable beneficiary, contact our office for instructions.
6. Beneficiary Classes (unless otherwise specified in the designation):

   PRIMARY or the first person(s)/entity(ies) in line to receive the death proceeds after the insured is deceased.

   CONTINGENT or the second or subsequent person(s)/entity(ies) in line to receive the death proceeds after the insured is deceased and no surviving primary beneficiary(ies).

   SECOND CONTINGENT or the third or subsequent person(s)/entity(ies) in line to receive the death proceeds after the insured is deceased and no surviving primary or contingent beneficiary(ies).
7. If your beneficiary is a Trust, see page five.

Beneficiary Designation

Designations given in dollar amounts will not be accepted. However, designations given in percentages or fractions equal to 100% will be accepted.

If joint beneficiaries are named in any of the three classes (Primary, Contingent, or Second Contingent), the proceeds are to be paid equally to the survivors unless otherwise stated.

If you are adding beneficiaries but not changing existing beneficiaries, you must restate all existing beneficiaries.

Change beneficiaries on: (select one)

- ☐ Base policy
- ☐ Children term rider(s)
- ☐ Primary Insured Rider
- ☐ First to die rider
- ☐ Last to die rider
- ☐ Other Insured rider – on the life of _____

If you do not select one of the options, we will automatically change the beneficiaries on the base policy and the primary insured rider (if applicable).

For Trust and Custodian Designations see page 5.

If no fractions or percentages are given, proceeds will be paid equally to the survivor or survivors, if any in the class (ie: primary, contingent, or second contingent).

Primary Beneficiary(ies) (Submit more pages as necessary.) This information is required in order to assist us in identifying and contacting your beneficiary(ies) in the event of a claim / distribution and ensure benefits are paid out appropriately. State regulations may require benefits be paid to the State if the beneficiary cannot be located in a timely manner.

The first person(s)/entities in line to receive the death proceeds after the insured is deceased.

Full Legal Name *(First, Middle, Last)*: ____________________

Beneficiary's Mailing Address: ____________________

City: ____________________ State: __________ Zip: __________

Social Security Number / EIN*: ____________________ Date of Birth: ____________________

Daytime Telephone Number: ____________________

Email Address: ____________________

Relationship to Insured: ____________________

Percentage of Proceeds: ____________ %

Full Legal Name *(First, Middle, Last)*: ____________________

Beneficiary's Mailing Address: ____________________

City: ____________________ State: __________ Zip: __________

Social Security Number / EIN*: ____________________ Date of Birth: ____________________

Daytime Telephone Number: ____________________

Email Address: ____________________

Relationship to Insured: ____________________

Percentage of Proceeds: ____________ %

Full Legal Name *(First, Middle, Last)*: ____________________

Beneficiary's Mailing Address: ____________________

City: ____________________ State: __________ Zip: __________

Social Security Number / EIN*: ____________________ Date of Birth: ____________________

Daytime Telephone Number: ____________________

Email Address: ____________________

Relationship to Insured: ____________________

Percentage of Proceeds: ____________ %

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Contingent Beneficiary(ies) (Submit more pages as necessary.)

This information is required in order to assist us in identifying and contacting your beneficiary(ies) in the event of a claim / distribution and ensure benefits are paid out appropriately. State regulations may require benefits be paid to the State if the beneficiary cannot be located in a timely manner.

The second or subsequent person(s)/entity(ies) in line to receive the death proceeds after the insured is deceased and no surviving primary beneficiary(ies).

Full Legal Name *(First, Middle, Last)*: _____

Beneficiary's Mailing Address: _____

City: _____ State: _____ Zip: _____

Social Security Number / EIN*: _____ Date of Birth: _____

Daytime Telephone Number: _____

Email Address: _____

Relationship to Insured: _____

Percentage of Proceeds: _____ %

Contingent Beneficiary(ies) (Submit more pages as necessary.)

Full Legal Name *(First, Middle, Last)*: _____

Beneficiary's Mailing Address: _____

City: _____ State: _____ Zip: _____

Social Security Number / EIN*: _____ Date of Birth: _____

Daytime Telephone Number: _____

Email Address: _____

Relationship to Insured: _____

Percentage of Proceeds: _____ %

Second Contingent Beneficiary(ies) (Submit more pages as necessary.)

The third or subsequent person(s)/entity(ies) in line to receive the death proceeds after the insured is deceased and no surviving primary or contingent beneficiary(ies).

Full Legal Name *(First, Middle, Last)*: _____

Beneficiary's Mailing Address: _____

City: _____ State: _____ Zip: _____

Social Security Number / EIN*: _____ Date of Birth: _____

Daytime Telephone Number: _____

Email Address: _____

Relationship to Insured: _____

Percentage of Proceeds: _____ %

* The submission of a completed IRS Form W-9 may be required. Employer Identification Number for Trusts or Entities.

Trust Designation (Submit more pages as necessary.)

This information is required in order to assist us in identifying and contacting your beneficiary(ies) in the event of a claim / distribution and ensure benefits are paid out appropriately. State regulations may require benefits be paid to the State if the beneficiary cannot be located in a timely manner.

If the beneficiary is a Trust, complete the following, listing all Trustees.

☐ Primary Beneficiary ☐ Contingent Beneficiary ☐ Second Contingent

Full Legal Name(s): _____

Name of Trustee(s): _____

Trust Mailing Address: _____

City: _____ State: _____ Zip: _____

Employer Identification Number / SSN*: _____ Date of Trust**: _____

Daytime Telephone Number: _____

Email Address: _____

Percentage of Proceeds: _____ %

* The submission of a completed IRS Form W-9 may be required. Employer Identification Number for Trusts or Entities
** The date the trust was established.

Custodian Designation (Submit more pages as necessary.)

If the beneficiary is a custodian on behalf of a minor, complete the following if applicable.

Note: Minor Beneficiaries—Any payment due to a minor beneficiary shall be made to the legally appointed guardian of the minor, unless otherwise permitted by law. If you are designating a minor beneficiary, we suggest you contact your legal advisor to consider doing so under the UNIFORM GIFTS TO MINORS ACT (UGMA), or UNIFORM TRANSFERS TO MINORS ACT (UTMA), whichever may be in effect in your state.

Name of Custodian *(First, Middle, Last)*: _____

Custodian's Mailing Address: _____

City: _____ State: _____ Zip: _____

Daytime Telephone Number: _____

Email Address: _____

As Custodian for:

Name of Minor *(First, Middle, Last)*: _____

under the UTMA/UGMA of the State of: _____

Minor's Mailing Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Birth: _____

Daytime Telephone Number: _____

Authorizations and Signatures

I certify that the information provided on this form is complete and correct:

Owner's Signature _____ Date _____

Name (print or type) _____ **Title*** _____

Owner's Signature** _____ Date _____

Name (print or type) _____ **Title*** _____

Irrevocable Beneficiary Signature (if applicable) _____ Date _____

Name (print or type) _____ **Title*** _____

Witness Signature*** (Massachusetts only) _____ Date _____

Name (print or type) _____ **Title*** _____

* Required for a corporation, partnership, or trust

** See addendum for multiple owner policies

*** A witness signature of a disinterested party is required in the state of Massachusetts.

Signature Requirements

Owner	Signature(s) Required—Digital/Electronic signatures will not be accepted.
Individual(s)*	Policyowner(s)
Corporation, Bank or Financial Institution	Signature of one officer with title, and a corporate resolution which names all officers authorized to sign on behalf of the corporation; or two officer's signatures, with title, without corporate resolution.
Conservator or POA	Signature of Conservator or POA with title. We require Letter of Conservatorship along with court order designating conservator/guardian or copy of the POA document to be on file. If POA is dated more than 3 years, we require an affidavit to accompany the request. **Signature Example: John Doe, POA for Jane Doe.**
Trust	Signature of all trustee(s) with title along with the completed Certification of Trustee Powers form AN07086.
Partnership or LLC	We require one general/managing partner signature with title and a copy of the Partnership agreement for Partnerships OR one managing member's signature with title and a copy of the operating agreement for LLCs.
Custodian/Minor	We require court order - "Letter of Guardianship" or UGMA or UTMA paperwork. (If the custodian designation was completed on page 3, additional paperwork is not required.)
Signed by an "X"	If signor is unable to sign and must sign with an "X," we require signature be notarized.
Stamped signatures	We will not knowingly accept a stamped signature.
All other interested parties	Contact customer service to verify signature(s) needed.
Titles	If you are signing the form in any capacity other than an individual an appropriate title is required.