PLEASE PRINT OR TYPE

Alfa Life Insurance Corporation
Change of Beneficiary

NO CORRECTIONS OR ERASURES WILL BE ACCEPTED.

DO NOT SUBMIT POLICY FOR THESE CHANGES

Service Center #	Policy Number	Name of Insured

Cancel all previous beneficiary designations and settlement options selected under the above numbered policy and change the beneficiary of the policy as designated below, with right of revocation.

PRIMARY BENEFICIARY: (Must be listed, even if remains same)

Full Name | Relationship To Insured

___ESTATE OF INSURED
___TRUST AGREEMENT: Name of Trust | Name of Trustee

(Attach copy of the page in trust agreement showing date and name of trust) Tax ID# of Trust

CONTINGENT BENEFICIARY:

Full Name | Relationship To Insured

___ESTATE OF INSURED
___TRUST AGREEMENT: Name of Trust | Name of Trustee

(Attach copy of the page in trust agreement showing date and name of trust) Tax ID# of Trust

It is agreed that these changes shall be an amendment to and form a part of the original application and policy. It is also agreed that THE ABOVE CHANGES SHALL BE EFFECTIVE ONLY WHEN RECORDED BY THE COMPANY AT ITS HOME OFFICE, BUT WHEN SO RECORDED SHALL TAKE EFFECT AS OF THE DATE SIGNED BY THE OWNER.

Date | **Witness** | **Signature of Policyowner**

THE UNDERSIGNED AGREES TO THE ABOVE CHANGES

Signature of Assignee (if any) | Signature of Irrevocable Beneficiary (if any)

THIS SPACE IS FOR HOME OFFICE USE ONLY

Alfa Life Insurance Corporation

By

Date Recorded | Officer of the Company