INDIVIDUAL ASSURANCE COMPANY, LIFE, HEALTH & ACCIDENT
3200 E. Memorial Road, Suite 100, Edmond, Oklahoma 73013 ♦ 1-800-821-5434
Mailing Address: P.O. Box 30685, Edmond, OK 73003-0012

CHANGE OF BENEFICIARY

Name	Date of Birth	Employer

I revoke all prior beneficiary designations and settlement option elections. I designate the following as beneficiaries under this policy:

Primary: ☐ Equal Shares, or total in "%" column must equal 100.

Name (print in full)	Relationship	Date of Birth	%

Contingent: ☐ Equal Shares, or total in "%" column must equal 100.

Name (print in full)	Relationship	Date of Birth	%

Include as ☐ First ☐ Contingent beneficiary all future children born of insured's present marriage, as of the date of this form.

It is understood and agreed that, unless otherwise directed, proceeds will be paid in equal shares to any primary beneficiaries who survive the insured, but if none survives, proceeds will be paid in equal shares to any contingent beneficiaries who survive the insured.

I direct that any amendment of the policy requested above take effect on the date this request is signed, but without any liability to the Company on account of payment made or action taken by it before this request was acknowledged by the Company.

Signature of Insured Employee	Social Security Number	Date

Signature of Employee Representative	Title	Date