Need to change your beneficiary, name, or request a new policy? See below.

Instructions:
1) Print form, complete sections that are applicable.
2) Have someone other than beneficiary witness signature.
3) Member's signature, printed name & SSN must be completed.
4) Send form (with original signature) to NGAT, 4332 Kenilwood Dr., Nashville, TN 37204-4401.
5) Questions? Please call 1-888-642-8448.

American Equity Life Insurance Company

POLICY SERVICE FORM

Tennessee National Guard Association

BENEFICIARY DESIGNATION

I (we) ask the beneficiary of the above policy be changed as shown below. All prior beneficiary designations are revoked. I (we) agree that the Company is free from liability in relying on a statement about birth, death, marriage, names, addresses and other facts concerning all beneficiaries from any other one. Unless otherwise stated, the survivors of a beneficiary class share equal amounts of the proceeds.

I would like to change my Beneficiary on my Group Life Policy to:

List beneficiary's full name and address	Relationship To insured	Date of Birth	% of Proceeds
_____	_____	___/___/___	_____
_____	_____	___/___/___	_____

List beneficiary's full name and address	Relationship To insured	Date of Birth	% of Proceeds
_____	_____	___/___/___	_____
_____	_____	___/___/___	_____

If none of the above are living or this designation is ineffective proceeds will be paid to the insured's estate. If you name a Trust as the Beneficiary, submit a copy of the trust for our file.

Unless the Company has been notified of a community property interest in this policy, the Company shall be entitled to rely on it's good faith belief that no such interest exists and assumes no responsibility for inquiry. The insured and/or policyowner signing this form agrees to indemnify and hold the Company harmless from the consequences of accepting this transaction.

1. NAME CHANGE : Insured

Former Name _____ New Name_____

Date Named Changed ___/___/___ Reason _____

2. **ADDRESS CHANGE**: Owner Insured

_____

Street City State zip

3. Lost policy Request :

____ I am unable to find the policy named above. I request that the company issue a Certificate, which validates all of the provisions of the last Policy.

_____ _____ Date ___/___/___

Witness Signature of Insured Member

Member's Name: _____ Member's SSN: _____

(Please Print)

The Company has recorded the change requested and retained a photocopy of the request. Date ___/___/___ By _____