



American Life & Security Corp.

Administrative Office

PO Box 717 * Frankfort, KY 40602-0717
Phone: 877.758.9333 Fax: 502.875.7084

BENEFICIARY CHANGE FORM

Policy Number:

POLICY NUMBER 1	POLICY NUMBER 2	POLICY NUMBER 3	POLICY NUMBER 4

Insured's Full Name: _____

Indicate "P" for Primary or "C" for Contingent

P / C	To:	Relationship	Age	Social Security No.

- Instructions:**
- (1) Please print
 - (2) Relationship, age and social security numbers of the beneficiary are required to process your request.
 - (3) This form must be notarized
 - (4) Return to our home office. *Address, fax and e-mail to the home office are listed above*

Signed at _____, _____ STATE

this _____ day of _____ YEAR

Owner's social security number is: _____

_____ Owner's Name (printed) _____ Owner's Signature

Owner's Street Address _____ City _____ State _____ Zip Code _____

Owner's email address _____ Day time phone: (____) _____ Home Cell Work

Co-Owner's social security number is: _____

_____ Co-Owner's Name (printed) _____ Co-Owner's Signature

Co-Owner's Street Address _____ City _____ State _____ Zip Code _____

Co-Owner's email address _____ Day time phone: (____) _____ Home Cell Work

Subscribed and sworn before me this _____ day of _____, _____.

State of: _____

County of: _____

My commission expires on _____

Notary Public