



POLICY OWNER'S BENEFICIARY CHANGE REQUEST

CICA LIFE OF AMERICA

Policyholder Services • P.O. Box 149151 • Austin TX 78714-9151 • Email: PHS.USA@citizensinc.com

Table with 4 columns: Policy Number (10-digits), Insured, Owner (If other than Insured), Date

INSTRUCTIONS: Complete Policy Number, Insured, Owner and Date line and the section(s) of the form to indicate your request. All fields are required for each beneficiary listed except SSN or Tax ID. Date and sign this form in the presence of a witness who will also sign.

Upon receipt at the home office, the requested changes will be processed subject to the policy provisions. Any request received by the Company more than 60 days after the date the request was signed will be returned to you for a current date and new signatures.

I direct any change to the policy requested above be affected upon the Company's acceptance and acknowledgment evidenced below. I understand a change of beneficiary designation shall take effect as of the Acknowledgment of Request for Change date and I agree the Company may waive any policy provision requiring return of the policy for endorsement, but at its discretion may require its return.

-----SIGN BELOW FOR THE ABOVE REQUEST(S) -----

Primary Beneficiary section: I hereby revoke all prior designations of primary beneficiary and request the designation(s) below: Includes table for Primary Beneficiary #1-4 with columns for Name, SSN or Tax ID, Address, Relationship to Insured, and Percentage.

Contingent Beneficiary section: I hereby revoke all prior designations of contingent beneficiary and request the designation(s) below: Includes table for Contingent Beneficiary #1-2 with columns for Name, SSN or Tax ID, Address, Relationship to Insured, and Percentage.

Signature of Witness

Signature of Insured or Owner, if other than Insured

Printed Witness Name

Date

HOME OFFICE USE ONLY
ACKNOWLEDGMENT OF REQUEST FOR CHANGE - PLEASE ATTACH TO POLICY

Dated on _____, 20____ by _____ Signature