



The Lincoln National Life Insurance Company  
Lincoln Life & Annuity Company of New York  
First Penn-Pacific Life Insurance Company  
(as in your contract and herein the "Company")

## Life Customer Service Contact Information

Mail: PO Box 21008, Greensboro, NC 27420-1008

Phone: 800-487-1485 Fax: 800-819-1987

Email: [CustServSupportTeam@LFG.com](mailto:CustServSupportTeam@LFG.com)

[www.LincolnFinancial.com](http://www.LincolnFinancial.com)

## Beneficiary Change for Life Policy

### General Information (Please type or print clearly.)

This section must be completed or your request will be declined.

Policy/Certificate No.: \_\_\_\_\_

Issued by (the Company): \_\_\_\_\_

### Insured Information

Full Legal Name (*First, Middle, Last*): \_\_\_\_\_

Insured's Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Daytime Telephone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

### Owner Information (If different from Insured. Submit more pages as necessary.)

Full Legal Name (*First, Middle, Last*): \_\_\_\_\_

Owner's Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security Number/EIN\*: \_\_\_\_\_ Date of Birth/Trust\*\*: \_\_\_\_\_

Daytime Telephone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

\*The submission of a completed IRS Form W-9 may be required. Employer Identification Number for Trusts or Entities

\*\*The date the trust was established

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## Instructions

Almost all beneficiary changes can be requested by using this form. However, if there is any question concerning the completion of the request or if a beneficiary designation is desired which cannot be requested on this form, contact your local representative or Agency which services your policy.

1. Complete a separate request for change of beneficiary for each policy to be changed, unless the owner and all information is the same for all policies.
2. A form which has been altered or on which there has been an erasure cannot be accepted unless the alteration or erasure is initialed by the policy owner(s).
3. This form is to be forwarded to the Company. A confirmation of the beneficiary change will be sent to you for your records.
4. This form is not to be used to elect an Optional Method of Settlement.
5. Irrevocable Beneficiaries: An irrevocable beneficiary is a designation that cannot be changed without the irrevocable beneficiary's written consent. It is also a designation that for any change (i.e. withdrawal, ownership change, etc.) to the policy/contract, we will require the irrevocable beneficiary to sign and date the request. If you are naming an irrevocable beneficiary, contact our office for instructions.
6. Beneficiary Classes (unless otherwise specified in the designation):
  - PRIMARY or the first person(s)/entity(ies) in line to receive the death proceeds after the insured is deceased.
  - CONTINGENT or the second or subsequent person(s)/entity(ies) in line to receive the death proceeds after the insured is deceased and no surviving primary beneficiary(ies).
  - SECOND CONTINGENT or the third or subsequent person(s)/entity(ies) in line to receive the death proceeds after the insured is deceased and no surviving primary or contingent beneficiary(ies).
7. If your beneficiary is a Trust, see page five.

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## Beneficiary Designation

***Designations given in dollar amounts will not be accepted. However, designations given in percentages or fractions equal to 100% will be accepted.***

If joint beneficiaries are named in any of the three classes (Primary, Contingent, or Second Contingent), the proceeds are to be paid equally to the survivors unless otherwise stated.

***If you are adding beneficiaries but not changing existing beneficiaries, you must restate all existing beneficiaries.***

Change beneficiaries on: (select one)

- ☐ Base policy
- ☐ Children term rider(s)
- ☐ Primary Insured Rider
- ☐ First to die rider
- ☐ Last to die rider
- ☐ Other Insured rider – on the life of \_\_\_\_\_

If you do not select one of the options, we will automatically change the beneficiaries on the base policy and the primary insured rider (if applicable).

**For Trust and Custodian Designations see page 5.**

If no fractions or percentages are given, proceeds will be paid equally to the survivor or survivors, if any in the class (ie: primary, contingent, or second contingent).

**Primary Beneficiary(ies)** (Submit more pages as necessary.) This information is required in order to assist us in identifying and contacting your beneficiary(ies) in the event of a claim / distribution and ensure benefits are paid out appropriately. State regulations may require benefits be paid to the State if the beneficiary cannot be located in a timely manner. If your beneficiary is a Trust, see pg. 5.

The first person(s)/entities in line to receive the death proceeds after the insured is deceased.

Full Legal Name (*First, Middle, Last*): \_\_\_\_\_

Beneficiary's Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security Number/EIN\*: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Daytime Telephone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_

Percentage or Fraction of Proceeds: \_\_\_\_\_

Full Legal Name (*First, Middle, Last*): \_\_\_\_\_

Beneficiary's Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security Number/EIN\*: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Daytime Telephone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_

Percentage or Fraction of Proceeds: \_\_\_\_\_

Full Legal Name (*First, Middle, Last*): \_\_\_\_\_

Beneficiary's Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security Number/EIN\*: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Daytime Telephone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_

Percentage or Fraction of Proceeds: \_\_\_\_\_

\* The submission of a completed IRS Form W-9 may be required. Employer Identification Number for Trusts or Entities

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**Contingent Beneficiary(ies)** (Submit more pages as necessary.) This information is required in order to assist us in identifying and contacting your beneficiary(ies) in the event of a claim / distribution and ensure benefits are paid out appropriately. State regulations may require benefits be paid to the State if the beneficiary cannot be located in a timely manner.

The second or subsequent person(s)/entity(ies) in line to receive the death proceeds after the insured is deceased and no surviving primary beneficiary(ies).

Full Legal Name (*First, Middle, Last*): \_\_\_\_\_

Beneficiary's Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security Number/EIN\*: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Daytime Telephone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_

Percentage or Fraction of Proceeds: \_\_\_\_\_

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**Contingent Beneficiary(ies)** (Submit more pages as necessary.)

Full Legal Name (*First, Middle, Last*): \_\_\_\_\_

Beneficiary's Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security Number/EIN\*: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Daytime Telephone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_

Percentage or Fraction of Proceeds: \_\_\_\_\_

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**Second Contingent Beneficiary(ies)** (Submit more pages as necessary.)

The third or subsequent person(s)/entity(ies) in line to receive the death proceeds after the insured is deceased and no surviving primary or contingent beneficiary(ies).

Full Legal Name (*First, Middle, Last*): \_\_\_\_\_

Beneficiary's Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security Number/EIN\*: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Daytime Telephone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_

Percentage or Fraction of Proceeds: \_\_\_\_\_

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\* The submission of a completed IRS Form W-9 may be required. Employer Identification Number for Trusts or Entities.

**Trust Designation** (Submit more pages as necessary.) This information is required in order to assist us in identifying and contacting your beneficiary(ies) in the event of a claim / distribution and ensure benefits are paid out appropriately. State regulations may require benefits be paid to the State if the beneficiary cannot be located in a timely manner.

If the beneficiary is a Trust, complete the following, listing all Trustees.

☐ Primary Beneficiary      ☐ Contingent Beneficiary      ☐ Second Contingent

Full Legal Name(s): \_\_\_\_\_

Name of Trustee(s): \_\_\_\_\_

Trust Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security Number/EIN\*: \_\_\_\_\_ Date of Trust\*\*: \_\_\_\_\_

Daytime Telephone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Percentage or Fraction of Proceeds: \_\_\_\_\_

\* The submission of a completed IRS Form W-9 may be required. Employer Identification Number for Trusts or Entities

\*\* The date the trust was established.

**Custodian Designation** (Submit more pages as necessary.)

If the beneficiary is a custodian on behalf of a minor, complete the following if applicable.

**Note:** Minor Beneficiaries—Any payment due to a minor beneficiary shall be made to the legally appointed guardian of the minor, unless otherwise permitted by law. If you are designating a minor beneficiary, we suggest you contact your legal advisor to consider doing so under the UNIFORM GIFTS TO MINORS ACT (UGMA), or UNIFORM TRANSFERS TO MINORS ACT (UTMA), whichever may be in effect in your state.

Name of Custodian (*First, Middle, Last*): \_\_\_\_\_

Custodian's Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Telephone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

**As Custodian for:**

Name of Minor (*First, Middle, Last*): \_\_\_\_\_

under the UTMA/UGMA of the State of: \_\_\_\_\_

Minor's Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Daytime Telephone Number: \_\_\_\_\_

## Authorizations and Signatures — Required

This page must be completed and returned or your request will be declined.

I certify that the information provided on this form is complete and correct:

**X**

Owner's Signature

Date\*

Name (print or type)

Title\*

**X**

Owner's Signature\*\*

Date\*

Name (print or type)

Title\*

**X**

Irrevocable Beneficiary Signature (if applicable; defined on page 2)

Date\*

Name (print or type)

Title\*

**X**

Witness Signature\*\* (Massachusetts Only)

Date\*

Name (print or type)

Title\*

\* Required

\*\* A witness signature of a disinterested party is required in the state of Massachusetts.

## Signature Requirements

Owner	Signature(s) Required
Individual(s)	Signature of the Policyowner(s)
Power of Attorney (POA)	Signature of POA with title. We require a copy of the POA document to be on file with Lincoln. If the POA is more than 3 years old, we require an affidavit that the POA is still current to accompany the request. <b>Signature Example: John Doe, Attorney-in-Fact for Jane Doe.</b>
Conservator or Guardian	Signature of Conservator or Guardian with title. We require Letter(s) of Conservatorship or Letters of Guardianship of the Estate to be on file with Lincoln.
Custodian of Minor	Signature of Custodian with title. We require a court order, or other documentation evidencing an appointment as Custodian under a state Uniform Transfers [Gifts] to Minors Act, to be on file with Lincoln.
Corporation, Bank or Financial Institution	Signature of one officer with title, and a corporate resolution which names all officers authorized to sign on behalf of the corporation; or two officer's signatures, with title, without corporate resolution.
Pension Plan	Signature of the Pension Plan Administrator and a copy of Plan documents naming the Administrator.
Trust	Signature of all trustee(s) with title along with the completed Certification of Trustee Powers form.
Partnership or LLC	Signature of one general/managing partner with title and a copy of the Partnership agreement for Partnerships OR one managing member's signature with title and a copy of the operating agreement for LLCs.
Signed by an "X"	Signature notarized, if the signor is unable to sign and must sign with an "X".
Stamped signatures	We will not knowingly accept a stamped signature.
All other interested parties	Contact customer service to verify signature(s) needed.
Titles	If you are signing the form in any capacity other than as an individual an appropriate title is required.