



WISCONSIN NATIONAL GUARD ASSOCIATION UNIVERSAL REQUEST FOR CHANGE FORM

WINGA • 2400 Wright Street, Room 162, Madison, WI 53704-2572 • (608) 242-3100



Only complete the section you wish to change. Complete a separate form for each life insurance account except for sections 2 & 3.

Social Security Number	Insured Name (Last, First, MI)	Phone Number
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1. CHANGE OF BENEFICIARY (Please see instructions on pages 3 and 4)

I hereby revoke any previous designation of beneficiaries and request that the life insurance benefit payable at my death be paid in accordance with the designations below. If more than one beneficiary is designated in the same beneficiary class, payment shall be made in equal shares to the designated beneficiaries unless otherwise provided herein. We must be informed of any legal restrictions affecting your beneficiary designations. **Note:** To comply with the laws of your state, beneficiary changes on 5Star Life Insurance Company ("5Star Life") forms, and not those changes contained in an insured's will or trust shall govern in cases of change. **Subject to the law of your state.** Beneficiary changes arising from a divorce are not binding on 5Star Life unless made in the above prescribed manner or referenced in a court order filed with 5Star Life prior to the death of the insured. If more space is needed for beneficiary designations, please add a separate signed and dated sheet.

PRIMARY BENEFICIARY(IES) CLASS

Full given name (First, Middle, Last) _____ Percentage _____

SSN ____ - ____ - _____ Relationship _____ Date of Birth ____ / ____ / ____ Phone Number _____

Full given name (First, Middle, Last) _____ Percentage _____

SSN ____ - ____ - _____ Relationship _____ Date of Birth ____ / ____ / ____ Phone Number _____

SECONDARY (OR CONTINGENT) BENEFICIARY(IES) CLASS

Full given name (First, Middle, Last) _____ Percentage _____

SSN ____ - ____ - _____ Relationship _____ Date of Birth ____ / ____ / ____ Phone Number _____

Full given name (First, Middle, Last) _____ Percentage _____

SSN ____ - ____ - _____ Relationship _____ Date of Birth ____ / ____ / ____ Phone Number _____

2. CHANGE OF NAME

Date of change ____ / ____ / ____ I elect to change the name of the Insured Spouse Dependent to the following:

Name before change _____ Name after change _____

3. CHANGE OF ADDRESS

Complete Address (including Zip Code) _____

Phone Numbers: Daytime ____ - ____ - _____ Cell ____ - ____ - _____ Evening ____ - ____ - _____

Email Address _____

4. CHANGE OF COVERAGE

I elect to change coverage to decrease coverage amount to: Member \$ _____ Spouse \$ _____ Children \$ _____

Cancel all SSLI coverage

5. DATE OF BIRTH CHANGE

Insured Spouse Dependent Date of Birth on Certificate ____ / ____ / ____ Correct Date of Birth ____ / ____ / ____

6. LOST STATEMENT COVERAGE REQUEST

Please send Certificate Schedule. Please send complete duplicate certificate/policy.

7. SIGNATURES

Sign and date this form and forward to 5Star Life. We will acknowledge receipt by returning a date stamped copy to you.

Please Note: The CURRENT insured MUST sign above to request this beneficiary change. The current insured's spouse should also sign as Wisconsin is a community property state.

Signature of Insured _____ Date ____ / ____ / ____
(Parent or guardian, if insured is a minor)

Signature of Spouse _____ Date ____ / ____ / ____