CHANGE OF BENEFICIARY

Ref: Section 607.02, Wis. Stat.

Return completed form to:
State of Wisconsin
Office of the Commissioner of Insurance
State Life Insurance Fund
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-0107 • 1-800-562-5558

INSTRUCTIONS: Complete information requested below. Date and sign in the presence of **two witnesses**. Forward to the above address.

Policy Owner	**Policy Number**

PRIMARY

I am exercising the right reserved to me in the policy number listed above to change the beneficiary to:

Name *(First, Middle I., Last)*	Relationship to Insured	Birth Date *(mm/dd/yyyy)*	Social Security Number

SECONDARY

If that person(s) is not living, thereafter to:

Name *(First, Middle I., Last)*	Relationship to Insured	Birth Date *(mm/dd/yyyy)*	Social Security Number

It is understood and agreed that all decisions upon question of fact in determining unnamed beneficiaries herein designated, made by the STATE LIFE INSURANCE FUND in good faith, based on proof of affidavit or other written evidence satisfactory to it, shall be conclusive and fully protect the STATE LIFE INSURANCE FUND in acting in reliance thereon.

This provision is subject to revocation and change at the request of the owner and during the lifetime of the insured.

OWNER:

Signature	Date	Social Security Number	Phone Number

Address	City, State, Zip

WITNESS:

Signature
Date
Address
City, State, and Zip

WITNESS:

Signature
Date
Address
City, State, and Zip

FOR FUND USE ONLY

This change is made effective _____

_____
Commissioner of Insurance