CHANGE OF BENEFICIARY
LIVING TRUST

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**

I am exercising the right reserved to me in the above policy to change the beneficiary clause to read as follows:

Name of Trust			Date of Trust *(mm/dd/yyyy)*
Contact Trustee – First Name	Middle Name	Last Name	
Contact Trustee Address – Street		Phone Number	
City, State, Zip			
Additional Trustee – First Name	Middle Name	Last Name	Phone
Additional Trustee – First Name	Middle Name	Last Name	Phone

Provided that the payment of the proceeds of this policy to said trustee(s) shall fully and finally discharge the State Life Insurance Fund (Fund) from all liability and, provided further that if at the death of the insured, the Trust referred to in this designation is not in effect and claim has not been properly filed under this policy, the proceeds may be paid by the Fund to the estate of the insured.

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