

## INDEPENDENT LIFE INSURANCE COMPANY

P.O. Box 679053 Dallas, Texas 75267-9053

Telephone:	(800)	793-0848	
Fax:	(214)	666-4833	

Policy/Contract I	Number:
-------------------	---------

## CONTINGENT PAYEE DESIGNATION / CHANGE REQUEST

1. MEASURING LIFE INFORMATION			
FIRST NAME	LAST NAME		
STREET ADDRESS	CITY	STATE	ZIP
TELEPHONE NUMBER	BIRTH DATE	SSN	
2. NEW CONTINGENT PAYEE DESIG		t the navee dies Attach additional	shoot if possessary)
(Contingent Payee, the person(s) to rec	eive the remainder of the proceeds in the ever	it the payee dies. Attach additional	sneet if necessary.)
NAME	RELATIONSHIP	%	
STREET ADDRESS	CITY	STATE	ZIP
TELEPHONE NUMBER	BIRTH DATE	SSN	
NAME	RELATIONSHIP	%	
STREET ADDRESS	CITY	STATE	ZIP
TELEPHONE NUMBER	BIRTH DATE	SSN	
NAME	RELATIONSHIP	%	
STREET ADDRESS	CITY	STATE	ZIP
TELEPHONE NUMBER	BIRTH DATE	SSN	

## 3. AUTHORIZATION

I request that the contingent payee(s) be changed in accordance with the contract's provisions. I represent that all statements and information contained herein are true and complete to the best of my knowledge and belief. This request replaces all prior contingent payee designations which are hereby revoked. This request relates only to the contract referenced above and no other contracts.

4. SIGNATURES					
PAYEE OR GUARDIAN SIGNATURE	PRINT NAME	DATE (mm/dd/yy)			
WITNESS SIGNATURE (must be a third party, disinterested adult)	PRINT NAME	DATE (mm/dd/yy)			



## 6. INSTRUCTIONS

This form should be printed, completed in full, signed by the payee or legal representative (if the individual signing is not the payee, legal documentation must accompany this request), and then submitted to Independent Life Insurance Company via email, fax, or mail.

Email: documents@Independent.Life

Fax: (214) 666-4833

Mail: Independent Life Insurance Company P.O. Box 679053

Dallas, Texas 75267-9053 Telephone: (800) 793-0848