

## Beneficiary Designation



### Securian Life Insurance Company Minnesota Life Insurance Company

Group Customer Service • 400 Robert Street North, St. Paul, MN 55101-2098

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#### INSTRUCTIONS

1. Clearly print or type the information.
2. Sign and date the completed form.
3. **Form return options:**
  - Attach and submit on: [www.LifeBenefits.com/FileTransfer](http://www.LifeBenefits.com/FileTransfer)
  - Fax to: 651-665-4827
  - Mail to: Securian Financial  
PO Box 64546  
St. Paul, MN 55164-0546

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#### GENERAL BENEFICIARY INFORMATION

- Completing this Beneficiary Designation form will revoke all current beneficiary designations.
- The same person(s) cannot be named as both a primary and contingent beneficiary.
- If you need more space, attach an additional sheet of paper with all of the information required. Be sure to sign and date this additional information page.
- To receive a death benefit, a beneficiary must survive the insured. If the named beneficiary does not survive the insured, that beneficiary's portion shall be equally distributed to the remaining beneficiaries within that category.
- When the signed and completed beneficiary form has been accepted, you will be mailed a confirmation.
- **Primary Beneficiary:** This is the individual(s), trust, charity, or estate that you want to receive the insurance benefit. You can divide the insurance proceeds between primary beneficiaries. The total shares must equal 100%.
- **Contingent Beneficiary:** If all the primary beneficiary(ies) are no longer living, eligible, or able to receive the benefits, it will be paid to the contingent beneficiary(ies) designated. You can divide the insurance proceeds between your named contingent beneficiaries. The total shares must equal 100%.
- **Naming Minor Children:** You may name your children (by name) directly, or to a trust. Minors cannot directly receive life insurance proceeds; however, they may be paid to a court-appointed guardian or held until the minor child is legal age.
- **Trust:** Provide the trust name, effective date and tax ID or Social Security number (if applicable) - i.e., "John Smith Trust dated 01/01/20xx."
- **Charity:** Provide the full name, address, tax ID number.

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|                                              |                                         |                                    |
|----------------------------------------------|-----------------------------------------|------------------------------------|
| Employer name<br><b>State of Minnesota</b>   |                                         | Policy number<br><b>28736/7166</b> |
| Insured's name (first, middle initial, last) |                                         | ID (or last four of SSN)           |
| Address (street, city, state, zip)           |                                         | Email address                      |
| Insured's date of birth                      | Policyowner (if different than insured) | Policyowner's phone number         |

**This designation applies to selected coverage(s).** If this section is left blank, your designation will apply to all coverages. If your beneficiary(ies) are different by coverage, use a separate beneficiary form for each coverage.

- ☐ All coverages
- ☐ Voluntary Accidental Death and Dismemberment - 28736
- ☐ Term Life - 7166

## PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit.

|                                                     |                          |                         |         |
|-----------------------------------------------------|--------------------------|-------------------------|---------|
| Beneficiary full name/trust name                    | Date of birth/trust date | Tax ID (SSN or EIN)     | Share % |
| Address (street, city, state, zip) and phone number |                          | Relationship to insured |         |
| Beneficiary full name                               | Date of birth            | Tax ID (SSN)            | Share % |
| Address (street, city, state, zip) and phone number |                          | Relationship to insured |         |
| Beneficiary full name                               | Date of birth            | Tax ID (SSN)            | Share % |
| Address (street, city, state, zip) and phone number |                          | Relationship to insured |         |

**Total Primary Shares Must Equal 100%**

## CONTINGENT BENEFICIARY(IES) - Receives a benefit ONLY if all primary beneficiaries are no longer living.

|                                                     |                          |                         |         |
|-----------------------------------------------------|--------------------------|-------------------------|---------|
| Beneficiary full name/trust name                    | Date of birth/trust date | Tax ID (SSN or EIN)     | Share % |
| Address (street, city, state, zip) and phone number |                          | Relationship to insured |         |
| Beneficiary full name                               | Date of birth            | Tax ID (SSN)            | Share % |
| Address (street, city, state, zip) and phone number |                          | Relationship to insured |         |
| Beneficiary full name                               | Date of birth            | Tax ID (SSN)            | Share % |
| Address (street, city, state, zip) and phone number |                          | Relationship to insured |         |

**Total Contingent Shares Must Equal 100%**

## SIGNATURE REQUIRED - This beneficiary form revokes all prior designations.

|                                                       |      |
|-------------------------------------------------------|------|
| Insured or policyowner's penned signature<br><b>X</b> | Date |
|-------------------------------------------------------|------|

**Community Property State Consent for current and former residents of Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin.** If you are married and live in, or previously lived in, a community property state and name someone other than your spouse as beneficiary, you may have your spouse sign below to waive his or her rights to any community property interest in the benefit. You should consult with a qualified tax advisor and/or seek legal advice if you have any questions in connection with the Beneficiary Designation.

As the Insured's spouse, I do hereby consent to the beneficiary designation(s) indicated on this form and waive any right that I may have to the proceeds of such insurance under applicable community property laws. My spouse may withdraw this designation at any time but may not designate a different primary beneficiary without my consent.

|                                 |                                  |             |
|---------------------------------|----------------------------------|-------------|
| Signature of spouse<br><b>X</b> | Please print spouse name clearly | Date signed |
|---------------------------------|----------------------------------|-------------|