TRANSAMERICA®
LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
Home Office: Cedar Rapids, IA
Administrative Office: PO Box 219
Cedar Rapids, IA 52406-0219

Beneficiary Information Form

Please complete the form below and send it to us in the enclosed business reply envelope. The information in the form is being requested to assist in identifying and paying claims benefits to the proper beneficiaries, should it become necessary, per your instructions.

PRIMARY INSURED

1. Last Name		First Name		M.I.
2. Address		Apt#	City	
State	Zip Code	3. Home Phone ( )	4. Date of Birth	5. Social Security Number

SPOUSE (If applying)

1. Last Name		First Name		M.I.
2. Address		Apt#	City	
State	Zip Code	3. Home Phone ( )	4. Date of Birth	5. Social Security Number

PRIMARY BENEFICIARY

Name / Address	DOB	Percent	Relationship	Phone #	SSN / Tax ID#
Total 100%					

CONTINGENT BENEFICIARY

Total 100%					

SPOUSE'S BENEFICIARY (complete only if spouse coverage was requested)

Name / Address	DOB	Percent	Relationship	Phone #	SSN / Tax ID#
Total 100%					

SPOUSE'S CONTINGENT BENEFICIARY(complete only if spouse coverage was requested)

Total 100**%**					

☐ I understand that the company has requested the information on this form be provided to assist in identifying and paying benefits to the proper beneficiaries. After review, I have elected not to provide any information that I did not supply on this form.

For residents of **California**: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of loss is guilty of a crime and may be subject to fines and confinement in state prison.

Owner/Primary Insured Signature	Date
Spouse's Signature (if applying)	Date