Protective Life * as Administrator for
The Lincoln National Life Insurance Company
P.O. Box 13694, Birmingham, AL 35202- 3641
Email Address: structuredsettlements@protective.com
Telephone: (800) 451-7065 Fax: (603) 334-5833

Policy/Contract Number: NP3-

BENEFICIARY DESIGNATION/CHANGE REQUEST

1. PAYEE(S) INFORMATION

First Name	Middle Name	Last Name		
Mailing Address - Street	City	State	ZIP	☐ **CHECK HERE IF NEW ADDRESS**
Telephone Number	Birth Date	Social Security Number		

2. BENEFICIARY CHANGE INSTRUCTIONS

The right to change beneficiaries is determined at the time of settlement and may be limited by the terms of your settlement documents. This beneficiary designation supersedes any previous designations. Please be sure to list the full name, relationship, percentage (designations must equal 100%), and address in the primary and contingent sections depending on how the payee would like to designate each beneficiary. If you do not specify the percentage of benefit to be paid, payment will be made in equal shares. Make sure all signatures are obtained, including witness.

3. PRIMARY BENEFICIARY DESIGNATION INFORMATION (*Primary Beneficiary:* the person(s) you choose to receive the remainder of the proceeds in the event the payee dies. Attach additional sheet if necessary.)

Name	Relationship	%	Social Security Number	Birth Date
Mailing Address - Street	City	State	ZIP	Telephone Number
Name	Relationship	%	Social Security Number	Birth Date
Mailing Address - Street	City	State	ZIP	Telephone Number
Name	Relationship	%	Social Security Number	Birth Date
Mailing Address - Street	City	State	ZIP	Telephone Number

4. CONTINGENT BENEFICIARY DESIGNATION INFORMATION (*Contingent Beneficiary:* the person(s) you choose to receive the remainder of the proceeds in the event all the primary beneficiary(ies) die before the payee. Attach additional sheet if necessary.)

Name	Relationship	%	Social Security Number	Birth Date
Mailing Address - Street	City	State	ZIP	Telephone Number
Name	Relationship	%	Social Security Number	Birth Date
Mailing Address - Street	City	State	ZIP	Telephone Number
Name	Relationship	%	Social Security Number	Birth Date
Mailing Address - Street	City	State	ZIP	Telephone Number

5. AUTHORIZATION

I(We) hereby request that the beneficiary(ies) be changed in accordance with the provisions of the contract. I(We) represent that all statements and information contained herein are true and complete to the best of my(our) knowledge and belief. This request replaces all prior beneficiary designations which are hereby revoked. Unless otherwise indicated, the proceeds of the contract will be paid in equal shares to surviving beneficiaries of the same order. Unless otherwise provided by law, the right to revoke or to change any beneficiary designation is hereby reserved. This request relates only to the contract referenced above and no other contracts.

6. SIGNATURES

Payee(s) or Guardian Signature	Print Name	Date (mm/dd/yy)
Witness Signature (Must be a third party disinterested adult) Only needed in the state of MA	Print Name of Witness	Date (mm/dd/yy)