## OSGLI —VGLI Beneficiary Designation/Change

First Name:	formation in this section	n is required.		MI:
Last Name:				
Control #:		(See Billing Statement)	Social Security #:	
Address:				
City:				
State:	ZIP Code:		Check here	e if your address has changed
Email:				
Daytime Phone:			Evening Phone:	
1. Widow or w 2. Child(ren) in 3. Parent(s) in 6	idower; if none to equal shares, with the s equal shares; if none to nted executor or admini	fic beneficiary, your insurance share of any deceased child d	istributed among the desc	vors as follows: endants of that child; if none to

## INSTRUCTIONS FOR COMPLETING THIS FORM

Use this form to designate or make changes to the beneficiary(ies) of your VGLI death proceeds. The information on this form will replace any prior beneficiary designation. You may name anyone or any entity as your beneficiary without anyone knowing or consenting to it. You may change your beneficiary at any time by completing a new VGLI Beneficiary Designation/Change form. This form cannot be used to reinstate your coverage if your insurance is not in force due to failure to pay timely premiums.

## INSTRUCTIONS FOR DESIGNATING A PRIMARY OR CONTINGENT BENEFICIARY (SECTION 2)

- You may name more than one primary and more than one contingent beneficiary. This form allows you to name up to three primary and three contingent beneficiaries.
- You can name an individual, corporation/organization, trust, or an estate as a beneficiary. The following examples may be helpful in designating beneficiaries:

Individual: "Mary A Doe"

- Each name should be listed as first name, middle name, last name ("Mary A Doe," not "Mrs M Doe").
- Include the address, relationship and Social Security number for each individual listed.
- Indicate the percentage to be assigned to each individual.

Estate: "Estate of the Insured"

- Select "Estate" in the box provided.
- Indicate the percentage to be assigned to the estate.

Charitable Institution: "ABC Charitable Organization"

- Select "Charitable Institution" as the Beneficiary Description.
- Write the legal name of the Charitable Institution in the space for the First name.
- You must provide the address, city and state of operation for each Charitable Institution listed.
- Indicate the percentage to be assigned to the Charitable Institution.

Trust: See page 4



	Control #:	(See Billing Statement)							
2	<b>BENEFICIARY DESIGNATION</b> I hereby revoke any previous designation of primary beneficiary(ies) and contingent beneficiary(ies), if any, and in the event of my death, designate the following:								
	under Payment	eneficiaries beneficiary(ies) to receive 36 equal monthly payments rather than a Option. If you choose 36 payments, the beneficiary cannot choose ant the beneficiary to have a choice at the time of payment, leave	to receive a lump sum pa						
	<b>A. Primary Beneficiaries</b> are the person(s) or entity you choose to receive your life insurance proceeds. Payment will be made in equal shares unless otherwise specified. In the event that a designated primary beneficiary predeceases the Insured, the proceeds will be paid to the remaining primary beneficiaries in equal shares or all to the sole remaining primary beneficiary. The total for all primary beneficiaries must equal 100%.								
	1. Type (Select One) Gender:	Child Parent Spouse Other Family Other  Male Female	Trust Estate	Charitable Institution					
	First Name:			MI:					
	Last Name:								
	Address:								
	Phone: Payment:	SSN: SSN:		Share: %					
	2. Type (Select One) Gender:	Child Parent Spouse Other Family Other  Male Female	Trust Estate	Charitable Institution					
	First Name:			MI:					
	Last Name:								
	Address: Phone:	SSN:							
	Payment:	Lump Sum 36 Installments		Share: %					
	3. Type (Select One) Gender:	Child Parent Spouse Other Family Other  Male Female	Trust Estate	Charitable Institution					
	First Name:	Ividic I ellidic		MI:					
	Last Name:								

36 Installments

SSN:

Address: Phone:

Payment:

Lump Sum

Share:

**TOTAL**: ON THIS PAGE (must equal 100)

Control #:			(See E	Billing Statement)				
beneficiary(ies) of the event that a	die (or the ent designated co	ity dissolves ontingent be	s) before yo neficiary p	u die. Payment w	ill be made i sured, the p	n equal sha	ares unless	proceeds if the pri otherwise specified the remaining cont
1. Type (Select One) Gender:	Child Male	Parent Female	Spouse	Other Family	Other	Trust	Estate	Charitable Inst
First Name:								MI:
Last Name:								
Address: – Phone: _					SSN:			
Payment:	Lump Sum	36	6 Installme	nts				Share:
2. Type (Select One)	Child	Parent	Spouse	Other Family	Other	Trust	Estate	Charitable Inst
Gender:	Male	Female						
First Name:								MI:
Last Name:								
Address: – Phone: _					SSN:			
Payment:	Lump Sum	36	3 Installme	nts	3311.			Share:
3. Type (Select One)	Child	Parent	Spouse	Other Family	Other	Trust	Estate	Charitable Inst
Gender:	Male	Female						
First Name:								MI:
Last Name:								
Address:					0011			
Phone:			Nagata II	-t-	SSN:			Charri
Payment:	Lump Sum	36	3 Installme	NTS				Share:
							TOTAL: ON THIS I (must equ	PAGE LIL

Control #:	(See	e Billing Statement)
3 TRUST DES		ETE IF A TRUST HAS BEEN NAMED AS A BENEFICIARY
•	•	s a primary or contingent beneficiary in Section 2. Fill in the name and address for Agreement in the space provided.
<ul><li>Select "Trus</li><li>Indicate the</li></ul>	n Doe Trust. A Trust with a trust t" as the Type in section 2. percentage to be assigned to th e section below, Trust Designat	
1. Trustee Name: (First, MI, Last) Address:		
2. Trustee Name: (First, MI, Last) Address:		
And successor(s) in	n trust, as Trustee(s) under	Title of Agreement
Dated MM -	Date of Agreement	as amended and executed by me and said Trustee.

## 4 AUTHORIZATION / SIGNATURE

I authorize OSGLI to record and consider the individuals/institutions that I have named on this form as beneficiaries for VGLI benefits, specifically those names I have entered in paragraph 2A ("Primary Beneficiaries") and also paragraph 2B ("Contingent Beneficiaries"). If designating a trust as beneficiary, I have completed paragraph 3 ("Trust Designation"), and I understand OSGLI assumes no obligation as to the validity or sufficiency of any executed Trust Agreement and does not pass on its legality. In making payment to any Trustee(s), OSGLI has the right to assume that the Trustee(s) is acting in a fiduciary capacity until notice to the contrary is received by OSGLI. I agree that if OSGLI makes any payment(s) to the Trustee(s) before notice is received, OSGLI will not make payment(s) again.

Veteran's Signature:	Date: MM — DD — Y Y Y Y
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The veteran must sign and date this form.

The signature date must be the date the veteran actually signed the form.

Submit the completed form to:

OSGLI
P O BOX 41618
Philadelphia, PA 19176-9913

Keep a copy for your records.