



Transamerica Life Insurance Company
Home Office: Cedar Rapids, IA
Administrative Office P.O. Box 869094
Plano, TX 75086-9817

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%						
<p>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.</p>						
Owner/Primary Insured Signature			Date			
Spouse's Signature (if applying)			Date			