Individual Life Insurance

Brighthouse FINANCIAL

Life Insurance Change of Beneficiary

Use this form to change Beneficiaries on your life insurance policies.

The company indicated in this section is referred to as "the Company."

☐ Brighthouse Life Insurance Company of NY ☐ New England Life Insurance Company

☐ Brighthouse Life Insurance Company

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Things to know before you begin

- This form applies to all Brighthouse Financial companies.
- Only the Owner of the insurance policy is authorized to change Beneficiaries. If there is more than one Owner, all Owners must sign.
- This form must reflect all Beneficiaries, both Primary and Contingent, who should receive the proceeds of the policy(ies) listed below.
- If the Insured dies without a surviving Beneficiary, payment will be made to the Owner, if living, otherwise payment will be made to the Owner's Estate.

Definitions

- **Owner:** The person(s), business, charity, Trust, or entity with the right to make all decisions regarding the policy.
- **Insured:** The person who is insured by the policy(ies) and upon whose death the Beneficiaries will receive the proceeds of the claim. The Insured may also be the Owner.
- **Primary Beneficiary:** This is the person/party you select to receive life insurance proceeds after the Insured's death.
- **Contingent Beneficiary:** This is the person/party you select to receive life insurance proceeds after the Insured's death if no Primary Beneficiaries survive the Insured.
- **Testamentary Trust:** A Trust created and funded by the Insured's Will which only becomes active upon the death of the Insured.
- **Living *(Inter Vivos)* Trust:** A Trust created during the lifetime of the Grantor *(person who established the Trust)*.

Please provide information about the person (the Insured) covered by the insurance policy or insurance policies.

SECTION 1 - Insured

Policy number(s): 1. _____ 2._____3. _____

First name	Middle name	Last name

Street address

City	State	ZIP

Date of birth *(mm/dd/yyyy)*	Phone number	Social security number

Email address

Life insurance will be paid to the people you name below after the Insured's death.

SECTION 2 - Designate Your Primary Beneficiary

Complete one of the five Primary Beneficiary options below.

You **MUST** name a Primary Beneficiary for us to accept this form.

OPTION A - Individual Beneficiaries

- If you wish to designate more than three Individuals as Primary Beneficiaries, attach a signed and dated sheet listing the additional beneficiaries including all details requested in this form and identifying their role as a Primary Beneficiary.

- If you would like to divide the proceeds equally, or if you are checking the box below to include future children of the Insured as Primary Beneficiaries, leave the "percent (%) of proceeds" fields blank. If you prefer to designate different percentages, complete the "percent (%) of proceeds" fields for each individual.

First name	Middle name	Last name		**% of proceeds**
Street address		Country of citizenship		
City		State	ZIP	
Date of birth *(mm/dd/yyyy)*	Phone number	Social security number	Relationship to Insured	

First name	Middle name	Last name		**% of proceeds**
Street address		Country of citizenship		
City		State	ZIP	
Date of birth *(mm/dd/yyyy)*	Phone number	Social security number	Relationship to Insured	

First name	Middle name	Last name		**% of proceeds**
Street address		Country of citizenship		
City		State	ZIP	
Date of birth *(mm/dd/yyyy)*	Phone number	Social security number	Relationship to Insured	

Total = 100%

You have the option to include all future children *(born of, or adopted by, the Insured)* as Primary Beneficiaries by checking the box below.

☐ Yes, I want to include future children of the Insured as Primary Beneficiaries.

Please understand:
- Checking this box requires proceeds to be divided equally among all Primary Beneficiaries.
- Any living child not listed at the time you complete this form will be excluded as a Primary Beneficiary.

OPTION B - Testamentary Trust Created in the Insured's Will

☐ I choose the Trust created in the Insured's Will as my Primary Beneficiary.

OPTION C - Living *(Inter Vivos)* Trust Described Below

☐ I choose the Trust identified below as my Primary Beneficiary.

Name of Trust		Date of Trust *(mm/dd/yyyy)*	State where Trust was created
Trust address - Street		Trust tax ID	Phone number
City	State		ZIP

Trust Grantor- First name	Middle name	Last name

Grantor address - Street	Phone number	
City	State	ZIP

Contact Trustee - First name	Middle name	Last name

Contact Trustee address - Street	Phone number	
City	State	ZIP

Additional Trustee(s) - First name	Middle name	Last name	Phone number
First name	Middle name	Last name	Phone number

OPTION D - Business Entity Beneficiary, Its Successors or Assigns

Note: when a business entity is designated as the Primary Beneficiary, no Contingent Beneficiary may be named.

Name of Business Entity	Type of Entity *(Corporation, Partnership, Charity, etc.)*	
Permanent address - Street	Tax ID number	Phone number
City	State	ZIP

OPTION E - Insured's Estate

You may select the Insured's Estate as either a Primary or Contingent Beneficiary. If you select the Insured's Estate as a Primary Beneficiary, no Contingent Beneficiary may be named.

☐ I choose the Insured's Estate as the Primary Beneficiary.

SECTION 3 - Designate Your Contingent Beneficiary

(Complete this section only if you selected Option A, B, or C in Section 2 above.)

Complete one of the five Contingent Beneficiary options below.

OPTION A - Individual Beneficiaries

- If you wish to designate more than three Individuals as Contingent Beneficiaries, attach a signed and dated sheet listing the additional beneficiaries including all details requested in this form and identifying their role as a Contingent Beneficiary.
- If you would like to divide the proceeds equally, or if you are checking the box below to include future children of the Insured as Contingent Beneficiaries, please leave the "percent (%) of proceeds" fields blank. If you prefer to designate different percentages, complete the "percent (%) of proceeds" fields for each individual.

First name	Middle name	Last name		**% of proceeds**
Street address		Country of citizenship		
City		State	ZIP	
Date of birth *(mm/dd/yyyy)*	Phone number	Social security number	Relationship to Insured	

First name	Middle name	Last name		% of proceeds
Street address		Country of citizenship		
City		State	ZIP	
Date of birth *(mm/dd/yyyy)*	Phone number	Social security number	Relationship to Insured	

First name	Middle name	Last name		% of proceeds
Street address		Country of citizenship		
City		State	ZIP	
Date of birth *(mm/dd/yyyy)*	Phone number	Social security number	Relationship to Insured	

Total = 100%

You have the option to include all future children *(born of, or adopted by, the Insured)* as Contingent Beneficiaries by checking the box below.

☐ Yes, I want to include future children of the Insured as Contingent Beneficiaries.

Please understand:

- Checking this box requires proceeds to be divided equally among all Contingent Beneficiaries.
- Any living child not listed at the time you complete this form will be excluded as a Contingent Beneficiary.

OPTION B - Testamentary Trust Created in the Insured's Will

☐ I choose the Trust created in my Will as my Contingent Beneficiary.

OPTION C - Living *(Inter Vivos)* Trust

☐ I choose the Trust identified below as my Contingent Beneficiary

Name of Trust	Date of Trust *(mm/dd/yyyy)*	State where Trust was created
Trust address - Street		Phone number
City	State	ZIP

Trust Grantor - First name	Middle name	Last name	
Grantor address - Street	Trust tax ID number	Phone number	
City	State	ZIP	

Contact Trustee - First name	Middle name	Last name	
Contact Trustee address - Street		Phone number	
City	State	ZIP	

Additional Trustee(s) - First name	Middle name	Last name	Phone number
First name	Middle name	Last name	Phone number

OPTION D - Business Entity Beneficiary, Its Successors or Assigns

Name of Business Entity	Type of Entity *(Corporation, Partnership, Charity, etc.)*	
Permanent address - Street	Tax ID number	Phone number
City	State	ZIP

OPTION E - Insured's Estate

☐ I choose the Insured's Estate as my Contingent Beneficiary.

SECTION 4 - Optional Beneficiary Provisions and Requests for Children

(Check all provisions you wish to include.)

☐ **Payment to the Issue of a Deceased Child** ***(Per Stirpes):*** If a child of the Insured is named as a Beneficiary and that child dies before the Insured, that child's share of the proceeds will be paid to that child's living children in equal shares.

☐ **Custodian** under the Uniform Transfers or the Uniform Gifts to Minors Act *(UTMA or UGMA)* acting for Minor Beneficiary. Selecting a Custodian for each Minor that you have included as a Beneficiary may help speed up the payment process.

Please include just one Minor Beneficiary and Custodian per line.
(You can list the same Custodian for multiple Beneficiaries.)

Name of Custodian_____as Custodian for

Name of Minor_____under the State of_____UTMA/UGMA

Permanent address of Custodian - Street	Social security number	Phone number
City	State	ZIP

Name of Custodian_____as Custodian for

Name of Minor_____under the State of_____UTMA/UGMA

Permanent address of Custodian - Street	Social security number	Phone number
City	State	ZIP

Name of Custodian _____ as Custodian for

Name of Minor _____ under the State of_____UTMA/UGMA

Permanent address of Custodian - Street	Social security number	Phone number
City	State	ZIP

☐ **Simultaneous Death:** If any Beneficiary dies within 30 days after the Insured's death, the Beneficiary will be considered to have predeceased (died before) the Insured for the purpose of distributing the proceeds.

SECTION 5 - General Provisions

- The Company may rely on an affidavit of the Owner or other adult in determining family relationships and in identifying members of a class.
- Trust Beneficiaries:
  - If the Trust fails to make claim for the policy proceeds within 12 months after receiving notification of the Insured's death, or if the Company receives satisfactory written evidence that the Trust is not in effect, payment will be made as if the Trust was not named as a Beneficiary.
  - Before making payment to any Trust, the Company reserves the right to require satisfactory written evidence that the Trust is in effect and evidence of the identity of the Trustee(s) who are qualified to act on behalf of the Trust. The Company shall be fully protected in acting in reliance upon such evidence.
  - The Company's responsibility for the payment of proceeds ends with the payment to the Trustee(s); it has no responsibility regarding any subsequent distribution.
- The Company is requested to waive any policy provision requiring the endorsement of the policy.
- The Company is authorized to consider a fax or a photocopy of this signed form as valid as the original signed form.
- The Company is authorized to make any clarifying additions or amendments to this Change of Beneficiary form.

SECTION 6 - Certification & Signatures

Signature Requirements

- Each Policy Owner must sign this form. If an Owner is also the Insured or a Beneficiary, they only need to sign, date, and print their name.
- If there are more than two Owners, each additional Owner must sign and print their name, date their signature, provide their address, date of birth, phone number, and social security number. Space is reserved for this on page eight.
- Any Irrevocable Beneficiary must also sign this form.
- If any Owner lives in Massachusetts, that Owner's signature must be witnessed by a disinterested person over age 18 who is not being named as a Beneficiary. In all other states, witnessing by a disinterested adult is not required but is strongly recommended.
- Any Witness to the Owner's signature must be present when the Owner signs this form.
- If someone else is signing on behalf of an Owner, the full names of both Owner and signer must be provided. Be sure to include copies of any documents proving legal authority – such as power of attorney, guardianship papers, etc.

Individual Owner(s)

By signing below, I certify that I have read and agree to the contents of this form. I am revoking any previous designation of Beneficiaries and any Settlement Option and/or Optional Income Plan election choices for the life insurance policies listed on this form.

Signature of Owner		Date signed *(mm/dd/yyyy)*
First name	Middle name	Last name
Street address		
City	State	ZIP
Date of birth *(mm/dd/yyyy)*	Phone number	Social security number
Email address		
Witness to signature		Date signed *(mm/dd/yyyy)*
Print name - First	Middle	Last name

Signature of Joint Owner		Date signed *(mm/dd/yyyy)*
First name	Middle name	Last name
Street address		
City	State	ZIP
Date of birth *(mm/dd/yyyy)*	Phone number	Social security number
Email address		
Witness to signature		Date signed *(mm/dd/yyyy)*
Printed name - First	Middle	Last name

Corporate, Partnership, Charity, or Trust Owned Signature(s)

Please sign as shown below:

Trust owned	Signatures, followed by the word "Trustee," of all required Trustees.
Corporate/Charity owned	Signature and title of one authorized officer *(other than the Insured).*
Partnership owned	Signature and title of one authorized partner *(other than the Insured).*
Limited Liability Company owned	Signature and title of one authorized individual *(other than the Insured).*
Sole Proprietorship owned	Signature of Owner, followed by the title "Sole Owner."

By signing below, I certify that I have read and agree to the contents of this form. I am revoking any previous designation of Beneficiaries and any Settlement Option and/or Optional Income Plan election choices for the life insurance policies listed on this form.

Name of Corporation, Partnership, Charity, or Trust	EIN or SSN	If Trust, date of Trust *(mm/dd/yyyy)*
Street address		
City	State	ZIP
Signature		Date *(mm/dd/yyyy)*
Title		Phone number
Print name - First	Middle	Last name
Witness to signature		Date *(mm/dd/yyyy)*
Print name - First	Middle	Last name

Name of Corporation, Partnership, Charity or Trust	EIN or SSN	If Trust, date of Trust *(mm/dd/yyyy)*

Street address		

City	State	Zip

Signature	Date *(mm/dd/yyyy)*

Title	Phone number

Print name - First	Middle	Last name

Witness to signature	Date signed *(mm/dd/yyyy)*

Printed name - First	Middle	Last name

If you have previously named Irrevocable Beneficiaries, they must sign and date below.

Irrevocable Beneficiary signature	Date signed *(mm/dd/yyyy)*

First name	Middle name	Last name

Street address		

City	State	ZIP

Reserved for Additional Signatures

Page 9 is for information only and is not part of the completed form.

Reserved for Administrative Office Clarifications

SECTION 7 - How to Submit This Form

Please send us the first eight pages of this form and any additional listings you created by fax or mail.

Issuing Company	Contact Phone Numbers	Fax Number	Contact Address
Brighthouse Life Insurance Company Brighthouse Life Insurance Company of NY	1-800-882-1292	1-877-246-8424	For Non-Variable Life Policies: Brighthouse Financial P.O. Box 4363 Clinton, IA 52733-4363 For Variable Life Policies: Brighthouse Financial P.O. Box 4301 Clinton, IA 52733-4301
New England Life Insurance Company	1-800-388-4000	1-401-827-3156	P.O. Box 392 Warwick, RI 02887-0392
New England Life Insurance Company EEA COLI Products Only	1-888-458-2654	1-877-203-4970	Brighthouse Financial NEF EEA COLI P.O. Box 4270 Clinton, IA 52733-4270