



National Integrity Life Insurance Company

A member of Western & Southern Financial Group

Request for Policy Service

Dept. 1600

COX	CONTRACT NUMBER	NAME OF INSURED	
OWNER'S NAME		OWNER'S EMAIL ADDRESS	
OWNER'S (Area Code) TELEPHONE NO.		OWNER'S ADDRESS (No., Street, City, State, Zip Code)	
		OWNER'S (SSN)	

A. Beneficiary Designation B. Name Change C. Duplicate Contract

A. BENEFICIARY DESIGNATION - Completion of this form revokes all prior designations for all Classes; therefore, all Classes need to be redesignated. For the purpose of establishing priority, Class I is higher than Class II, and Class II is higher than Class III. **Child Beneficiaries:** You may designate children individually or as a group (e.g., "children of the insured"). We recommend designating children individually unless you intend to include later born or adopted children. If you designate a group, all natural and legally adopted children in the group who are living when payment is due will be beneficiaries even if you list individual children beneath the group designation. By designating a group, you understand and agree that the Company will be relieved of liability if it pays a claim in good faith reliance on an affidavit or other written evidence satisfactory to the Company identifying unnamed members of the group. **The SSN and Date of Birth are not required for a group designation.** However, if provided, it will help locate your beneficiary quicker when a claim has been presented for processing. The Privacy Policy Notice is available upon request. **PLEASE PRINT CLEARLY.** *For beneficiary changes in the state of Massachusetts, a witness signature is required. The witness must be over 18 and NOT DESIGNATED as a beneficiary. *

Class I (Primary) Beneficiary Designation			
Name		Relationship to Insured/Annuitant	Percentage %
Address		City	State Zip Code
Email Address	Telephone Number	Social Security Number	Date of Birth

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Name		Relationship to Insured/Annuitant	Percentage %
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Class I (Primary) Beneficiary Designation			
Name		Relationship to Insured/Annuitant	Percentage %
Address		City	State Zip Code
Email Address	Telephone Number	Social Security Number	Date of Birth

Class II (Contingent) Beneficiary Designation			
Name		Relationship to Insured/Annuitant	Percentage %
Address		City	State Zip Code
Email Address	Telephone Number	Social Security Number	Date of Birth



INSURED/ANNUITANT NAME	COX	POLICY NUMBER
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Class II (Contingent) Beneficiary Designation

Name		Relationship to Insured/Annuitant	Percentage %
Address	City	State	Zip Code
Email Address	Telephone Number	Social Security Number	Date of Birth

Class III (2nd Contingent) Beneficiary Designation

Name		Relationship to Insured/Annuitant	Percentage %
Address	City	State	Zip Code
Email Address	Telephone Number	Social Security Number	Date of Birth

Class III (2nd Contingent) Beneficiary Designation

Name		Relationship to Insured/Annuitant	Percentage %
Address	City	State	Zip Code
Email Address	Telephone Number	Social Security Number	Date of Birth

When your written request is received and approved by us at our Administrative Office, 400 Broadway, Cincinnati, OH 45202, it will take effect as of the date you signed it. It will not apply to any payment we make or other action we take before the request is approved. A confirmation notice will be provided for the owner's records. Any single sum or installment due upon or after death of the insured will be paid in equal shares, unless otherwise specified, to the beneficiaries in the class highest in the order of priority who are living on the due date of such single sum or installment.

Beneficiary designation is not effective unless recorded by the Company at its Home Office. A confirmation will be provided for the Owner's records.

B. NOTICE OF CHANGE OF NAME (Do Not Submit Contract; sign at bottom)

(Do not use this form to change ownership to another person.)

The correct name of the Owner Beneficiary Insured

is: _____
Owner Name

_____ Owner Address (No., Street, City, State, Zip Code)

Owner Date of Birth _____ Owner SSN _____ Owner (Area Code) Telephone No. _____

Reason for Change: _____

Provide legal documentation for all name changes, except name changes due to marriage or divorce.

C. DUPLICATE CONTRACT

Said contract has not been and is not now assigned nor has it been otherwise transferred or encumbered in any manner whatsoever and no person, firm or corporation has or claims the right to possession of said contract.

Explain how the contract was lost or destroyed. _____



INSURED/ANNUITANT NAME	COX	POLICY NUMBER
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Signed at _____ Date _____ Sign Here _____
CITY, STATE SIGNATURE OF OWNER

Sign Here _____ Witness _____
ADDITIONAL SIGNATURE OF OWNER (if applicable) Required for beneficiary changes in the state of Massachusetts. The witness must be over 18 and NOT DESIGNATED as a beneficiary** (if applicable)

*Your signature MUST be notarized if:

- 1) The Company has requested a notarized signature.
- 2) You have signed with an "X." In this case, you MUST provide an explanation below:

STATE OF _____)
 COUNTY _____) ss:
 OF _____)

SUBSCRIBED AND SWORN TO BEFORE me, the undersigned Notary Public, this _____ day of _____, _____.

 Notary Public

State of _____

Spousal consent (if applicable)

If you reside or have resided in a community property state (AZ, CA, ID, LA, NV, NM, TX, WA, or WI), and have not named your spouse sole beneficiary of this contract, your spouse may need to consent to a non-spouse being designated as beneficiary for any portion of its benefits. You may obtain such consent by having your spouse sign below. **The Company is not liable for any consequences resulting from your failure to obtain proper consent.**

I have reviewed this beneficiary designation and, as spouse of the contract owner, I consent to it and waive any rights I may have to the contract proceeds to the extent of this designation. This consent supersedes any prior spousal consent regarding the contract.

Signature of Owner's Spouse _____ Date Signed _____

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 a loss is guilty of a crime and may be subject to fines and confinement in state prison.

