Additional Beneficiary Designations for Inforce Policies/Contracts Form

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American National / One Moody Plaza, Galveston, TX 77550-7947

Overnight Address

Annuity Services: Mailing Processing Center, Attn: Annuity 10427, 1949 E. Sunshine St. Springfield, MO 65899-0001 / **Phone** 1-800-252-9546

Life Insurance Services: Mailing Processing Center, Attn: LIS 3257, 1949 E. Sunshine St. Springfield, MO 65899-0001 / **Phone** 1-800-899-6806

Variable Contracts: One Moody Plaza, Galveston, TX 77550-7947 / **Phone** 1-800-306-2959

Mailing Address

Annuity Services: Mailing Processing Center, P.O. Box 10427, Springfield, MO 65808-0427

Life Insurance Services: Mailing Processing Center, P.O. Box 3257, Springfield, MO 65808-3257

Variable Contracts: P.O. Box 1893, Galveston, TX 77553-1893

For Use With the Following Companies

American National Insurance Company
American National Life Insurance Company of Texas
Garden State Life Insurance Company
American National Life Insurance Company of New York
Standard Life and Accident Insurance Company

Business is conducted in New York by American National Life Insurance Company of New York, headquartered in Glenmont, New York.

Instructions

This is not a stand-alone form. It is only to supplement the Beneficiary Change Request Form.

- Completion of these forms replaces all previous Beneficiary designations.
- These forms must reflect ALL Beneficiaries, both Primary and Contingent, who should receive proceeds of the policy listed below.

1 Current Information

Insured/Annuitant's First Name | M.I. | Last Name | Policy/Contract Number

Owner's First Name | M.I. | Last Name | Date of Birth

Owner's Street Address | City | State | ZIP

E-mail Address | Telephone

Joint Owner's First Name | M.I. | Last Name | Date of Birth

Joint Owner's Street Address | City | State | ZIP

E-mail Address | Telephone

2 Additional Primary Beneficiary Designations

▶ **NOTE:** Unless specified, Beneficiaries within the same class share equally. Allocations must add up to 100%. Fractional allocations will not be accepted (Example: 1/3). Complete as much information as possible for each beneficiary.

Use Full Legal Names

First Name ____ M.I. ____ Last or Non-Natural Entity Name ____ Gender ☐ Male ☐ Female

Allocation (Whole % Only) ____ ☐ Share Equally

Date of Birth ____ SSN/TIN ____ Relationship to Insured/Annuitant ____

Street Address ____ City ____ State ____ ZIP ____

E-mail Address ____ Telephone ____

First Name ____ M.I. ____ Last or Non-Natural Entity Name ____ Gender ☐ Male ☐ Female

Allocation (Whole % Only) ____ ☐ Share Equally

Date of Birth ____ SSN/TIN ____ Relationship to Insured/Annuitant ____

Street Address ____ City ____ State ____ ZIP ____

E-mail Address ____ Telephone ____

First Name ____ M.I. ____ Last or Non-Natural Entity Name ____ Gender ☐ Male ☐ Female

Allocation (Whole % Only) ____ ☐ Share Equally

Date of Birth ____ SSN/TIN ____ Relationship to Insured/Annuitant ____

Street Address ____ City ____ State ____ ZIP ____

E-mail Address ____ Telephone ____

3 Additional Contingent Beneficiary Designations

▶ **NOTE:** Unless specified, Beneficiaries within the same class share equally. Allocations must add up to 100%. Fractional allocations will not be accepted (Example: 1/3). Complete as much information as possible for each beneficiary. **Contingent Beneficiary(ies) will be paid only if no Primary Beneficiary(ies) survive the Insured.**

Use Full Legal Names

First Name ____ M.I. ____ Last or Non-Natural Entity Name ____ Gender ☐ Male ☐ Female

Allocation (Whole % Only) ____ ☐ Share Equally

Date of Birth ____ SSN/TIN ____ Relationship to Insured/Annuitant ____

Street Address ____ City ____ State ____ ZIP ____

E-mail Address ____ Telephone ____

First Name ____ M.I. ____ Last or Non-Natural Entity Name ____ Gender ☐ Male ☐ Female

Allocation (Whole % Only) ____ ☐ Share Equally

Date of Birth ____ SSN/TIN ____ Relationship to Insured/Annuitant ____

Street Address ____ City ____ State ____ ZIP ____

E-mail Address ____ Telephone ____

First Name ____ M.I. ____ Last or Non-Natural Entity Name ____ Gender ☐ Male ☐ Female

Allocation (Whole % Only) ____ ☐ Share Equally

Date of Birth ____ SSN/TIN ____ Relationship to Insured/Annuitant ____

Street Address ____ City ____ State ____ ZIP ____

E-mail Address ____ Telephone ____

4 Special Requests

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5 State Specific Fraud Language

For California Residents:
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.

6 Acknowledgment and Signatures

Signature requirements:

- Each Owner must print their name, then sign and date the form to indicate approval of the change.
- If there is an Irrevocable Beneficiary or an Assignee, they must also print their name, then sign and date the form to indicate their approval of the change.
- Each signature requires a disinterested witness signature. A disinterested witness is an adult that is not being named Beneficiary and is not otherwise signing this form. (Required in MA only) The Agent's signature is recommended.
- If someone else is signing on behalf of an Owner, the full names of both the Owner and the Signer must be provided. Include copies of any documents proving legal authority, such as power of attorney, guardianship papers, etc.
- If the Owner is a legal entity: trust, business or on behalf of Owner as guardian or power of attorney, include any necessary documents needed for legal authorization.

I understand that by signing below, I am revoking all previous beneficiary designations, and the changes on this form will become effective on the date I sign this form.

Owner:

Print Owner's Full Name | **Title** (Required for Officer, Trustee or Power of Attorney)

x
Signature of Owner | **Date:** Month / Day / Year

Print Agent or Witness's Full Name (Required in MA ONLY)

x
Signature of Agent or Witness (Required in MA ONLY) | **Date:** Month / Day / Year

Joint Owner (If Applicable):

Print Joint Owner's Full Name | **Title** (Required for Officer, Trustee or Power of Attorney)

x
Signature of Joint Owner | **Date:** Month / Day / Year

Print Agent or Witness's Full Name (Required in MA ONLY)

x
Signature of Agent or Witness (Required in MA ONLY) | **Date:** Month / Day / Year

Irrevocable Beneficiary or Assignee (if applicable):

Print Irrevocable Beneficiary or Assignee's Full Name | **Title** (Required for Officer, Trustee or Power of Attorney)

x
Signature of Irrevocable Beneficiary or Assignee | **Date:** Month / Day / Year

Print Agent or Witness's Full Name (Required in MA ONLY)

x
Signature of Agent or Witness (Required in MA ONLY) | **Date:** Month / Day / Year

For Home/Administrative Office Endorsement Only

Agency Code 1- | CSSD Code 2- | City | State

Processor's First Name | M.I. | Last Name | Date

This request has been recorded at the Home/Administrative Office of American National and its affiliates.
Effective Date of Change