AMERICAN EQUITY INVESTMENT LIFE INSURANCE COMPANY

Home Office
P.O. Box 71216
Des Moines, IA 50325
Toll Free 1-888-221-1234
Fax 1-515-221-0138

Pell City Office
P.O. Box 527
Pell City, AL 35125
Toll Free 1-877-508-9888
Fax 1-205-884-7928

Policy # _____

Insured _____

Social Security #

POLICY SERVICE FORM

BENEFICIARY DESIGNATION

I (we) ask the beneficiary of the above policy be changed as shown below. All prior beneficiary designations are revoked. I (we) agree that the Company is free from liability in relying on a statement about birth, death, marriage, names, addresses and other facts concerning all beneficiaries from any other one. Unless otherwise stated, the survivors of a beneficiary class share equal amounts of the proceeds.

I would like to change my Beneficiary on my Group Life Policy to:

	List beneficiary's full name and address	Relationship To insured	Date of Birth	% of Proceeds
Primary	_____	_____	_____	____
	_____	_____	_____	____
Contingent	List beneficiary's full name and address	Relationship To insured	Date of Birth	% of Proceeds
	_____	_____	_____	____
	_____	_____	_____	____

I would like to change my Beneficiary on my Cancer Policy:

	List beneficiary's full name and address	Relationship To insured	Date of Birth	% of Proceeds
Primary	_____	_____	_____	____
	_____	_____	_____	____
Contingent	List beneficiary's full name and address	Relationship To insured	Date of Birth	% of Proceeds
	_____	_____	_____	____
	_____	_____	_____	____

If none of the above are living or this designation is ineffective proceeds will be paid to the insured's estate. If you name a Trust as the Beneficiary, submit a copy of the trust for our file.

Unless the Company has been notified of a community property interest in this policy, the Company shall be entitled to rely on it's good faith belief that no such interest exists and assumes no responsibility for inquiry. The insured and/or policyowner signing this form agrees to indemnify and hold the Company harmless from the consequences of accepting this transaction.

1. **NAME CHANGE** : Insured

Former Name _____ New Name_____

Date Named Changed _____ Reason _____

2. **ADDRESS CHANGE**: Owner Insured

_____
Street City State zip

3. **Lost policy Request** :

____ I am unable to find the policy named above. I request that the company issue a Certificate, which validates all of the provisions of the last Policy.

_____ _____ Date _____
Witness Signature of Owner

The Company has recorded the change requested and retained the original of the request. Date _____ By _____