



708 Heartland Trail Ste 1800 \* Madison WI 53717  
 Policyholder Services: 888-863-6674  
 Fax: 877-584-2777  
 Email: [LifeClaims@OxfordLife.com](mailto:LifeClaims@OxfordLife.com)  
 Website: [cflic.com](http://cflic.com)

**SPOUSAL CONTINUATION REQUEST FORM**

Please read all instructions carefully and complete all applicable sections of this form. Unclear or missing information may delay or prevent processing. Sign and date the form and submit all pages. The Annuity Claim form must accompany this form.

**DECEDENT INFORMATION**

NAME OF DECEASED	FIRST	MIDDLE	LAST
POLICY NUMBER 1	EFFECTIVE DATE	POLICY NUMBER 2	EFFECTIVE DATE
		POLICY NUMBER 3	EFFECTIVE DATE

**NEW OWNER INFORMATION**

NEW OWNER NAME	TELEPHONE NUMBER (       )       --
MAILING ADDRESS	
CITY	STATE       ZIP + 4
NEW STREET ADDRESS (REQUIRED IF MAILING ADDRESS IS A PO BOX)	
CITY	STATE       ZIP + 4
NEW OWNER DATE OF BIRTH /       /	NEW OWNER SOCIAL SECURITY NUMBER ---       ---
NEW OWNER EMAIL	
IS THE NEW OWNER AS U.S. CITIZEN <input type="checkbox"/> YES <input type="checkbox"/> NO	IF NO, IS THE NEW OWNER A U.S. RESIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO

**Note:**

- For each beneficiary give full name, address, date of birth, Social Security number, relationship to insured, and percentage of death benefit.
- The sum of percentages for each beneficiary type (primary and contingent) must equal 100%.
- If percentages are left blank, all beneficiaries will receive equal shares.
- If you wish to designate more than two (2) primary or contingent beneficiaries, attach a signed and dated Supplemental Beneficiaries form.

## PRIMARY BENEFICIARY INFORMATION

<b>BENEFICIARY 1</b>		<b>PERCENTAGE</b>	TELEPHONE NUMBER (       )       --
MAILING ADDRESS			RELATIONSHIP
CITY		STATE	ZIP + 4
BENEFICIARY DATE OF BIRTH /       /	BENEFICIARY SOCIAL SECURITY NUMBER ---       ---	BENEFICIARY EMAIL	
<b>BENEFICIARY 2</b>		<b>PERCENTAGE</b>	TELEPHONE NUMBER (       )       --
MAILING ADDRESS			RELATIONSHIP
CITY		STATE	ZIP + 4
BENEFICIARY DATE OF BIRTH /       /	BENEFICIARY SOCIAL SECURITY NUMBER ---       ---	BENEFICIARY EMAIL	

## CONTINGENT BENEFICIARY INFORMATION

<b>BENEFICIARY 1</b>		<b>PERCENTAGE</b>	TELEPHONE NUMBER (       )       --
MAILING ADDRESS			RELATIONSHIP
CITY		STATE	ZIP + 4
BENEFICIARY DATE OF BIRTH /       /	BENEFICIARY SOCIAL SECURITY NUMBER ---       ---	BENEFICIARY EMAIL	
<b>BENEFICIARY 2</b>		<b>PERCENTAGE</b>	TELEPHONE NUMBER (       )       --
MAILING ADDRESS			RELATIONSHIP
CITY		STATE	ZIP + 4
BENEFICIARY DATE OF BIRTH /       /	BENEFICIARY SOCIAL SECURITY NUMBER ---       ---	BENEFICIARY EMAIL	

**OPTIONAL IRREVOCABLE BENEFICIARY PROVISION**

**OPTIONAL: Irrevocable Beneficiary Designation:**

If you wish to make a primary beneficiary designation named above irrevocable, print the irrevocable beneficiary's name in one of the spaces below and initial next to that irrevocable beneficiary's name.

**Note:** An irrevocable beneficiary receives a vested interest in the policy, and no changes to the policy, including surrender or a change of the beneficiaries, may be made by the owner without the signed consent of all irrevocable beneficiaries. If you do not initial next to the beneficiary's name below, the designation will be treated as revocable.

\_\_\_\_\_  
**Irrevocable Primary Beneficiary's Name**

\_\_\_\_\_  
**Owner's Initials**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Irrevocable Primary Beneficiary's Name**

\_\_\_\_\_  
**Owner's Initials**

\_\_\_\_\_  
**Date**

**CERTIFICATIONS AND SIGNATURES**

I have read, understood, and agreed to the contents of this form. *I hereby certify that:*

1. The answers recorded in this Spousal Continuation Request form are true and complete.
2. I make claim to the proceeds.
3. I agree that the Company's furnishing of this Spousal Continuation Request Form and any supplemental forms is not an admission that insurance was in force on the deceased's life, nor is it a waiver of its rights or defenses. This form is provided without prior verification of coverage and without any assurances that the person completing this form will be the appropriate payee or beneficiary.

_____ <b>New Annuitant/Owner's Signature</b>	_____ <b>New Annuitant/Owner's Printed Name</b>	_____ <b>Date</b>
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