Beneficiary Designation Form

Tel: (242) 326-6779
Fax: (242) 328-4141

NEW PROVIDENCE
LIFE INSURANCE COMPANY LIMITED

Part I: Policy Information (you must complete this section)	NIB number	
Customer ID	Main insured	
Plan name	Type of coverage (please check all that apply) ❑ Health ❑ Disability ❑ Life	

Part II: Primary Beneficiary Information *Total designated beneficiary share percentage must equal 100%.*

The undersigned hereby requests all previous primary beneficiary designation and settlement options elected be revoked and makes the following designations (if no entry is made, previous designations and or elections will remain unchanged):

Name	Date of Birth	Relationship to Insured	Percentage
Address		City	Phone Number
Name	Date of Birth	Relationship to Insured	Percentage
Address		City	Phone Number
Name	Date of Birth	Relationship to Insured	Percentage
Address		City	Phone Number

Part III: Contingent Beneficiary Information

Contingent (secondary) – Receives benefits ONLY if no primary beneficiary survives the insured. The undersigned hereby requests all previous contingent beneficiary designation and settlement options elected be revoked and makes the following designations (if no entry is made, previous designations and or elections will remain unchanged):

Name	Date of Birth	Relationship to Insured	Percentage
Address		City	Phone Number
Name	Date of Birth	Relationship to Insured	Percentage
Address		City	Phone Number
Name	Date of Birth	Relationship to Insured	Percentage
Address		City	Phone Number

_____ Date _____ /_____ /_____

Main insured signature

_____

Signature of policy owner *(with title if applicable)*

_____ Date _____ /_____ /_____

Policy owners telephone number Day Month Year

_____ Date _____ /_____ /_____

Signature of co-owner *(with title or second officer with title [if corporate owned])* Day Month Year

_____

Signature of witness *(person cannot be a designated beneficiary)*

_____ Date _____ /_____ /_____

Name of witness *(please print)* Day Month Year

_____ Date _____ /_____ /_____

Signature of beneficiary *(if applicable)* Day Month Year

Have you...	
❑	Completed Part I and provided us with complete policy owner information?
❑	Provided us with complete primary beneficiary information in Part II?
❑	Provided us with complete contingent beneficiary information in Part III, if applicable?
❑	Provided us with all appropriate signatures and dates?

Please submit this form via fax or email to your agent or:

New Providence Life Insurance Company Limited
Fax number: (242) 328-4141
Email: administrator@newprovidencelife.com