SUCCESSOR PAYEE / BENFICIARY DESIGNATION OR CHANGE REQUEST

Columbia Insurance Company
National Indemnity Company

PAYEE: _____

FILE NO.: _____

All successor payee ("beneficiary") designations or changes must be in writing on this form and signed by the Payee or the Payee's Legal Guardian. Should any of the named beneficiaries be minors at the time of Payee's death, documentation will be required supporting their guardianship. Payments will not be issued payable to minors**. Multiple beneficiaries may not be designated if this would result in any person receiving less than $100 per payment.** Please list below your individual beneficiary designation(s). The designation of "Spouse" may be used for a beneficiary to whom you are legally married.

Unless otherwise designated, benefits will be **equally or to the survivor** when more than one Primary Beneficiary is named. All Primary Beneficiary percentages must equal 100%. If you have more than two Primary Beneficiaries, please copy this form and attach the additional sheet. If no Primary Beneficiary survives the Payee, the remaining guaranteed payments shall be paid as designated to the Contingent Beneficiary(ies) who survive the Payee. If no Primary or Contingent Beneficiary survives the Payee, any remaining guaranteed payments will be paid to the Estate of the Payee.

PRIMARY **Beneficiary:** _____ %_____	**PRIMARY** **Beneficiary:** _____ %_____
Relationship to Claimant: _____	Relationship to Claimant:: _____
Social Security No.: _____	Social Security No.: _____
Date of Birth: _____	Date of Birth: _____
Mailing Address: _____	Mailing Address: _____
_____	_____
Email: _____	Email: _____
Phone No.: _____	Phone No.: _____

(Unless otherwise designated, benefits will be **equally or to the survivor** when more than one Contingent Beneficiary is named. All Contingent Beneficiary percentages must equal 100%. If you have more than two Contingent Beneficiaries, please copy this form and attach the additional sheet.)

CONTINGENT **Beneficiary:** _____ %_____	**CONTINGENT** **Beneficiary:** _____ %_____
Relationship to Claimant: _____	Relationship to Claimant:: _____
Social Security No.: _____	Social Security No.: _____
Date of Birth: _____	Date of Birth: _____
Mailing Address: _____	Mailing Address: _____
_____	_____
Email: _____	Email: _____
Phone No.: _____	Phone No.: _____

I hereby revoke all prior beneficiary designations and make the designations set forth above as to the file number indicated above. All beneficiary designations are subject to approval.

_____ _____ _____
Signature* Relationship to Payee Date

*If your notarized signature is not on file in our records, please have your signature notarized.

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____.

BY _____
NOTARY (SEAL)

DESIGNATION WILL NOT BE DEEMED EFFECTIVE UNTIL ACCEPTED.

Mailing/Overnight Address:
Structured Settlement Unit, 1314 Douglas Street, Suite 1400, Omaha, NE 68102-1944
Secured Fax: 866-262-9342