APPOINTMENT OF NEW BENEFICIARY

Please complete this form and forward to Protective Life Insurance Company
A recorded copy will be returned for filing with your Certificate of Insurance

Name of Insured: _____ **Term Life Plan**
Policy 104TLP
Certificate # _____

Name of Group: AMERICAN DENTAL ASSOCIATION **ADA #** _____

Any amount payable under the Accidental Death Benefit will be merged with the life insurance proceeds and paid out in the same manner, unless otherwise designated.

I hereby revoke any previous appointment and appoint the following as beneficiary of any moneys payable upon death.

DESIGNATION OF BENEFICIARY
PRIMARY (to include FULL NAME AND RELATIONSHIP for each entity)

Full Name	**Relationship**	**Percentage**

CONTINGENT
(if Primary Beneficiary predeceases Insured OR dies after Insured but before proceeds exhausted).

Full Name	**Relationship**	**Percentage**

DATED AT _____ **THIS** _____ **DAY OF** _____, _____
(City & State) *(Day)* *(Month)* *(Year)*

_____ _____
Signature of Owner (If Other Than Insured) **Signature of the Insured**