REQUEST FOR
CHANGE OF BENEFICIARY
STRUCTURED SETTLEMENTS

Allstate Life Insurance Company of New York
P.O. Box 660191, Dallas, TX 75266-0191
Phone: 1-800-237-3303 FAX: 1-877-690-4092

Please complete this form in its entirety.

STEP 1 - CONTRACT INFORMATION (ALL FIELDS MUST BE COMPLETED). Only one contract and Payee per change form. Submit a separate change of beneficiary form for each contract.

PAYEE'S NAME		CONTRACT #
SSN/EIN	DATE OF BIRTH	TELEPHONE NUMBER

STEP 2 - PRIMARY BENEFICIARY (IES) – If more than 2 Primary Beneficiaries, please use a separate sheet of paper and attach to this form. Percentages must add up to 100%.

A. Individual, Trust or Estate

Name of Primary Beneficiary #1	Name of Primary Beneficiary #2
☐ Equally **OR** ☐ Percentage* ______ % ***Whole Percentages ONLY**	☐ Equally **OR** ☐ Percentage* ______ % ***Whole Percentages ONLY**
Street Address	Street Address
City/State/Zip	City/State/Zip
SSN/TIN	SSN/TIN
Date of Birth (MM/DD/YYYY)	Date of Birth (MM/DD/YYYY)
Relationship	Relationship

B. Trust as Primary Beneficiary (NOT Under Last Will)

Name of Trust	Date of Trust
Name of Current Trustee	Trust Tax ID Number
Street Address	City/State/Zip

C. Trust as Primary Beneficiary (Trust Within Last Will)

To the trustee of the trust created pursuant to the Last Will and Testament of ____________________ (Name) as admitted to probate provided the trustee submits a written claim within six months of the death of the person that triggered payment under the contract. If no such claim is made by the trustee, the proceeds shall be paid to ____________________ (Name).

STEP 3 - CONTINGENT BENEFICIARY(IES) – If more than 2 Contingent Beneficiaries, please use a separate sheet of paper and attach to this form. Percentages must add up to 100%.

Name of Contingent Beneficiary #1	Name of Contingent Beneficiary #2
☐ Equally **OR** ☐ Percentage* ______ % ***Whole Percentages ONLY**	☐ Equally **OR** ☐ Percentage* ______ % ***Whole Percentages ONLY**
Street Address	Street Address
City/State/Zip	City/State/Zip
SSN/TIN ☐☐☐☐☐☐☐☐☐	SSN/TIN ☐☐☐☐☐☐☐☐☐
Date of Birth (MM/DD/YYYY) ☐☐☐☐☐☐☐☐	Date of Birth (MM/DD/YYYY) ☐☐☐☐☐☐☐☐
Relationship	Relationship

STEP 4 - IMPORTANT NOTE FOR MINOR CHILDREN DESIGNATED ABOVE:

Proceeds cannot be paid directly to a minor beneficiary. Proceeds can, however, be paid to an adult custodian for such minor beneficiary designated by the owner under the relevant state Uniform Transfers to Minors Act. (See instructions)

I designate ______________________________ ☐☐☐☐☐☐☐☐☐

Name — Custodian's SSN/TIN **(REQUIRED)**

____

Street Address — City — State — Zip

as Custodian of the funds payable to ______________________________ ☐☐☐☐☐☐☐☐☐ ,

Minor's Name — Minor's SSN/TIN

under the ______________ Uniform Transfers to Minors Act (or Uniform Gifts to Minors Act if SC or VT is

Name of State

designated). **NOTE:** If a custodian is named but no state-specific Uniform Transfers to Minors Act is designated Allstate Life Insurance Company of New York will use the provisions of New York UTMA.

Are all Beneficiaries, Custodians and/or Trustees U.S. Citizens? ☐ Yes ☐ No. If No, complete below.

Name	Name
Party to the Policy/Contract (i.e. "Trustee")	Party to the Policy/Contract (i.e. "Trustee")
Country of Citizenship	Country of Citizenship
Permanent Resident Card Number (Attach Copy if Possible)	Permanent Resident Card Number (Attach Copy if Possible)
Visa Number and Type (Attach Copy if Possible)	Visa Number and Type (Attach Copy if Possible)

STEP 6 - REQUIRED SIGNATURES

BY THIS REQUEST I HEREBY CANCEL ALL PRIOR BENEFICIARY DESIGNATIONS. THE BENEFICIARY CHANGE REQUEST IS NOT EFFECTIVE UNLESS AND UNTIL APPROVED BY THE CONTRACT OWNER. COMPLETION OF THIS FORM DOES NOT IMPLY THAT BENEFITS ARE GUARANTEED.

NOTICE TO ALL PARTIES COMPLETING THIS FORM: It is fraudulent to fill out this form with information you know to be false or knowingly omit important facts. Criminal and/or civil penalties may result from such acts. This change is subject to the provisions and limitations found in the contract.

SIGN HERE

PAYEE'S SIGNATURE	DATE	PRINT NAME
JOINT PAYEE'S SIGNATURE, IF APPLICABLE	DATE	PRINT NAME

STEP 7 - REQUIRED NOTARY SEAL AND SIGNATURE

State of)

) SS.

County of)

I, ______________________, do hereby certify ______________________ personally appeared before me this day and acknowledged the due execution of the foregoing instrument. Witness my hand and official seal this ______ day of ______________, 20____.

[SEAL]

____
NOTARY PUBLIC'S SIGNATURE

My commission expires on ______________________
(MM/DD/YYYY)

STEP 8 - SUBMISSION INSTRUCTIONS

Mail completed, signed and dated form to:

ALLSTATE LIFE INSURANCE COMPANY OF NEW YORK
P.O. Box 660191
Dallas, TX 75266-0191

STEP 9 - CONTRACT OWNER REQUIRED SIGNATURE - OFFICE USE ONLY

SIGN HERE

SIGNATURE	DATE	PRINT NAME