

Use this form to transfer policy ownership to an individual on an existing MassMutual policy. As a result of an ownership change, the new owner may have the right to update the beneficiary. If section D – New Beneficiary Information is not completed or the Revocable Assignment of Benefits (FR1114) is not submitted for Disability Income policies, the existing beneficiary/recipient of benefits will remain. See section E – Disclosures for definitions and exceptions. Any existing automatic programs on the Policy will remain unchanged unless otherwise requested. To name a funeral home as owner and/or beneficiary, contact Customer Service at 1-800-272-2216.

A Policy Information

- 1. Policy number(s):
2. Insured's full legal name: First MI Last Suffix

Current Owner's Information

- 3. Full legal name: First MI Last Suffix
4. Phone number: Home Work Cell
5. Email address:
6. Is this Policy subject to a divorce obligation? Yes No (Default)

If Yes, former spouse must sign in section F. Note: MassMutual must comply with applicable state law when divorce proceedings have been filed. If the MassMutual Policy is subject to a divorce obligation (for example, a court order or a divorce agreement), this form must also be signed by the former spouse.

B New Individual Owner Information

- 1. Type (Select one):
Insured(s)
One individual Owner during his/her lifetime and thereafter the Insured
One individual Owner during his/her lifetime and thereafter the individual Owner's estate
One individual Owner during his/her lifetime and thereafter a contingent Owner and thereafter the Insured
Joint with Right of Survivorship
Joint with Tenants-in-Common

1Right of Survivorship means if an Owner dies, the deceased Owner's portion will pass to the survivor(s) equally otherwise to the estate of which-ever said Owners is the last to die.

2If your policy is a Survivorship Whole Life, this ownership type may require a complex arrangement. Contact us to prepare a form for you.

3Tenants-in-Common means if an Owner dies, the deceased Owner's portion will pass to the estate of that deceased Owner.

Policy number(s): _____

B New Individual Owner Information *continued*

2. Full legal name: _____
First MI Last Suffix

3. Date of birth (mm/dd/yyyy): _____

4. Taxpayer Identification Number (SSN/ITIN): _____

5. Residential address – **do not use PO Box** (Street, Apt. or Suite #, City & State or Country, ZIP/Postal Code):

6. Mailing address – **only if different than question 5** (PO Box or Street, Apt. or Suite #, City & State or Country, ZIP/Postal Code):

7. Phone number: _____ Home Work Cell

8. Email address: _____

9. Relationship to Insured: _____

Complete for a Contingent/Joint Individual Owner

10. Full legal name: _____
First MI Last Suffix

11. Date of birth (mm/dd/yyyy): _____

12. Taxpayer Identification Number (SSN/ITIN): _____

13. Residential address – **do not use PO Box** (Street, Apt. or Suite #, City & State or Country, ZIP/Postal Code):

14. Mailing address – **only if different than question 13** (PO Box or Street, Apt. or Suite #, City & State or Country, ZIP/Postal Code):

15. Phone number: _____ Home Work Cell

16. Email address: _____

17. Relationship to Insured: _____

C Transfer of Value & Premium Payor Information ::

1. **Transfer of Value Certification.** The Current and New Owners certify that (Select one; if consideration left blank, assumed at \$0):
 The transfer is a gift or otherwise meets one of the exceptions to the “Transfer of Value” rule
 The transfer is not a gift and does not meet a “Transfer of Value” exception → Consideration: \$ _____

2. **Premium Payor Information (Optional).** Complete questions 2a-2c below if the New Owner will not be the Premium Payor. The New Owner automatically becomes the Premium Payor unless otherwise indicated below.

a. Full legal name: _____
First MI Last Suffix

b. Mailing address (PO Box or Street, Apt. or Suite #, City & State or Country, ZIP/Postal Code):

c. Relationship to Insured: _____

Policy number(s): _____

D New Beneficiary Information:.....

For entity beneficiaries, skip to question 3. For all beneficiaries within a class, the sum of the designated percentages must equal 100% or the sum of the designated dollar amounts must equal the total Face Amount of the Policy. If the distribution is blank, the death benefit will be divided equally between all beneficiaries within that class. To name additional beneficiaries, copy pages four or five as applicable. Be sure to submit all pages of this form to ensure accurate processing.

Individual Beneficiary Information

Complete this section to name an individual beneficiary. If both individual and entity beneficiaries are being named on this form, enter the entity information in question 3 on page 5.

1. Is any beneficiary being designated on this form considered a minor by the state in which they reside? Yes No (Default)

If No, skip to question 2. If Yes, continue to question 1a.

UTMA/UGMA. UTMA/UGMA refer to a state's law that governs the transfer of title to life insurance proceeds to a Custodian to manage for a minor until the minor reaches an age permitted by law. Under the UTMA/UGMA of the state designated in question 1d, the person designated in question 1a will be Custodian for the child(ren) named in this section. These custodial arrangements may only be used in U.S. states where permitted by applicable law. This does not extend to issue per stirpes, if selected.

a. Custodian's full legal name: _____
First MI Last Suffix

b. Custodian's date of birth (mm/dd/yyyy): _____

c. Custodian's mailing address (PO Box or Street, Apt. or Suite #, City & State or Country, ZIP/Postal Code):

d. Minor's resident state: _____

2. **Beneficiary arrangement** (Complete one row per individual beneficiary. If percentages are designated, the total under each class must equal 100%. If dollar amounts are designated, the total under each class should equal the Face Amount of the Policy.):

<p>Class (Select one):</p> <input type="checkbox"/> Primary <input type="checkbox"/> Secondary/Contingent <input type="checkbox"/> Tertiary	<p>Distribution (Select one):</p> <input type="checkbox"/> Equal shares (Default) <input type="checkbox"/> Specific percentage (Specify): _____ % <input type="checkbox"/> Specific amount (Specify): \$ _____ Issue per stirpes? <input type="checkbox"/> Yes <input type="checkbox"/> No (Default)
<p>Full legal name: _____ First MI Last Suffix</p>	
<p>Date of birth (mm/dd/yyyy): _____</p>	
<p>Taxpayer Identification Number: _____ <input type="checkbox"/> SSN <input type="checkbox"/> ITIN</p>	
<p>Mailing address (PO Box or Street, Apt. or Suite #, City & State/Country, ZIP/Postal Code): _____ _____</p>	
<p>Phone number: _____ <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell</p>	
<p>Email address: _____</p>	
<p>Relationship to Insured: _____</p>	

Continues on next page...

Policy number(s): _____

D New Beneficiary Information *continued*

Individual Beneficiary Information *continued*

2	Class (Select one): <input type="checkbox"/> Primary <input type="checkbox"/> Secondary/Contingent <input type="checkbox"/> Tertiary	Distribution (Select one): <input type="checkbox"/> Equal shares (Default) <input type="checkbox"/> Specific percentage (Specify): _____ % <input type="checkbox"/> Specific amount (Specify): \$ _____ Issue per stirpes? <input type="checkbox"/> Yes <input type="checkbox"/> No (Default)
	Full legal name: _____ First MI Last Suffix	
Date of birth (mm/dd/yyyy): _____		
Taxpayer Identification Number: _____ <input type="checkbox"/> SSN <input type="checkbox"/> ITIN		
Mailing address (PO Box or Street, Apt. or Suite #, City & State/Country, ZIP/Postal Code): _____ _____		
Phone number: _____ <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		
Email address: _____		
Relationship to Insured: _____		

3	Class (Select one): <input type="checkbox"/> Primary <input type="checkbox"/> Secondary/Contingent <input type="checkbox"/> Tertiary	Distribution (Select one): <input type="checkbox"/> Equal shares (Default) <input type="checkbox"/> Specific percentage (Specify): _____ % <input type="checkbox"/> Specific amount (Specify): \$ _____ Issue per stirpes? <input type="checkbox"/> Yes <input type="checkbox"/> No (Default)
	Full legal name: _____ First MI Last Suffix	
Date of birth (mm/dd/yyyy): _____		
Taxpayer Identification Number: _____ <input type="checkbox"/> SSN <input type="checkbox"/> ITIN		
Mailing address (PO Box or Street, Apt. or Suite #, City & State/Country, ZIP/Postal Code): _____ _____		
Phone number: _____ <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		
Email address: _____		
Relationship to Insured: _____		

Policy number(s): _____

D New Beneficiary Information *continued*

Entity Beneficiary Information

Complete the table below to name an entity as beneficiary. If both individual and entity beneficiaries are being named on this form, enter the individual information in question 2 on the previous page. Note: If either the estate of the Insured or a corporation is being named as the sole primary beneficiary, the Owner cannot name a secondary beneficiary.

3. Beneficiary arrangement (Complete one row per entity beneficiary. If percentages are designated, the total under each class must equal 100%. If dollar amounts are designated, the total under each class should equal the Face Amount of the Policy.):

1	Class (Select one): <input type="checkbox"/> Primary <input type="checkbox"/> Secondary/Contingent <input type="checkbox"/> Tertiary	Distribution (Select one): <input type="checkbox"/> Equal shares (Default) <input type="checkbox"/> Specific percentage (Specify): _____ % <input type="checkbox"/> Specific amount (Specify): \$ _____
	Type (Select one): <input type="checkbox"/> Irrevocable Trust <input type="checkbox"/> Revocable Trust <input type="checkbox"/> Trust under Insured's Will (Skip to next beneficiary) <input type="checkbox"/> Estate of Insured (Skip to next beneficiary) <input type="checkbox"/> Corporation <input type="checkbox"/> Other (Specify): _____ Full legal name: _____ Date Trust was established (Complete if Irrevocable Trust or Revocable Trust is selected above; mm/dd/yyyy): _____ Taxpayer Identification Number: _____ <input type="checkbox"/> EIN <input type="checkbox"/> ITIN <input type="checkbox"/> SSN Mailing address (PO Box or Street, Apt. or Suite #, City & State/Country, ZIP/Postal Code): _____ _____ Phone number: _____ <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell Email address: _____	

2	Class (Select one): <input type="checkbox"/> Primary <input type="checkbox"/> Secondary/Contingent <input type="checkbox"/> Tertiary	Distribution (Select one): <input type="checkbox"/> Equal shares (Default) <input type="checkbox"/> Specific percentage (Specify): _____ % <input type="checkbox"/> Specific amount (Specify): \$ _____
	Type (Select one): <input type="checkbox"/> Irrevocable Trust <input type="checkbox"/> Revocable Trust <input type="checkbox"/> Trust under Insured's Will (Skip to next beneficiary) <input type="checkbox"/> Estate of Insured (Skip to next beneficiary) <input type="checkbox"/> Corporation <input type="checkbox"/> Other (Specify): _____ Full legal name: _____ Date Trust was established (Complete if Irrevocable Trust or Revocable Trust is selected above; mm/dd/yyyy): _____ Taxpayer Identification Number: _____ <input type="checkbox"/> EIN <input type="checkbox"/> ITIN <input type="checkbox"/> SSN Mailing address (PO Box or Street, Apt. or Suite #, City & State/Country, ZIP/Postal Code): _____ _____ Phone number: _____ <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell Email address: _____	

