corebridge financial

The Variable Annuity Life Insurance Company (VALIC)
The United States Life Insurance Company in the City of New York (USL)
VALIC Retirement Services Company (VRSCO)

ADDITIONAL BENEFICIARY DESIGNATION SHEET

THIS FORM MUST BE ATTACHED TO THE BENEFICIARY DESIGNATION OR ANY APPLICATION/ENROLLMENT FORM TO MAKE THE REQUESTED CHANGE(S)

1. CLIENT INFORMATION

Name: _____ SSN or Tax ID _____

2. ADDITIONAL BENEFICIARY DESIGNATION

PRIMARY BENEFICIARIES:

Primary beneficiaries receive death benefits upon your death.

Percentage total must equal 100% for all designated primary beneficiaries.

Indicate additional primary beneficiaries below:

1. Name: _____ Phone: (_____) _____ DOB or Trust Date: _____ SSN or Tax ID: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Relationship: _____ Percent (Whole): _____ %

2. Name: _____ Phone: (_____) _____ DOB or Trust Date: _____ SSN or Tax ID: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Relationship: _____ Percent (Whole): _____ %

3. Name: _____ Phone: (_____) _____ DOB or Trust Date: _____ SSN or Tax ID: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Relationship: _____ Percent (Whole): _____ %

4. Name: _____ Phone: (_____) _____ DOB or Trust Date: _____ SSN or Tax ID: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Relationship: _____ Percent (Whole): _____ %

5. Name: _____ Phone: (_____) _____ DOB or Trust Date: _____ SSN or Tax ID: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Relationship: _____ Percent (Whole): _____ %

6. Name: _____ Phone: (_____) _____ DOB or Trust Date: _____ SSN or Tax ID: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Relationship: _____ Percent (Whole): _____ %

7. Name: _____ Phone: (_____) _____ DOB or Trust Date: _____ SSN or Tax ID: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Relationship: _____ Percent (Whole): _____ %

CONTINGENT BENEFICIARIES:

Contingent beneficiaries receive death benefits upon your death if all the primary beneficiaries are deceased or have waived their right to receive the benefits at the time of the your death.

Percentage total must equal 100% for all designated contingent beneficiaries.

Indicate additional contingent beneficiaries below:

1. Name: _____ Phone: (_____) _____ DOB or Trust Date: _____ SSN or Tax ID: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Relationship: _____ Percent (Whole): _____ %

2. Name: _____ Phone: (_____) _____ DOB or Trust Date: _____ SSN or Tax ID: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Relationship: _____ Percent (Whole): _____ %

3. Name: _____ Phone: (_____) _____ DOB or Trust Date: _____ SSN or Tax ID: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Relationship: _____ Percent (Whole): _____ %

4. Name: _____ Phone: (_____) _____ DOB or Trust Date: _____ SSN or Tax ID: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Relationship: _____ Percent (Whole): _____ %

5. Name: _____ Phone: (_____) _____ DOB or Trust Date: _____ SSN or Tax ID: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Relationship: _____ Percent (Whole): _____ %

6. Name: _____ Phone: (_____) _____ DOB or Trust Date: _____ SSN or Tax ID: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Relationship: _____ Percent (Whole): _____ %

7. Name: _____ Phone: (_____) _____ DOB or Trust Date: _____ SSN or Tax ID: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Relationship: _____ Percent (Whole): _____ %

3. CLIENT APPROVAL

I certify that the information provided above is true and correct. I request the contract/certificate issuer to make the requested change(s).

_____ _____

Client's Signature Date

All companies are wholly owned subsidiaries of Corebridge Financial, Inc.