

## REQUEST FOR CHANGE OF BENEFICIARY / NAME CHANGE / ADDRESS CHANGE

**PLEASE TYPE OR PRINT**

INSURED'S SOCIAL SECURITY #	POLICYHOLDER'S NAME (EMPLOYER/UNION)	POLICY NO.
<b>Insured's Name</b>		
<b>Street Address</b>		
<b>City, State, Zip</b>		

**BENEFICIARY CHANGE**

If the beneficiary is a trust, the information provided above should be for the trustee. If you have more than one beneficiary, attach a separate sheet of paper with the name, address, telephone number, date of birth, social security number and relationship (to you) for each beneficiary. Please date and sign.

**PRIMARY**

Name	Relationship	Address	Social Security #	Telephone
1.				
2.				

**CONTINGENT**

Name	Relationship	Address	Social Security #	Telephone
1.				
2.				

**NAME CHANGE** (Please note: For marriage or divorce you must provide proof of change)

FROM \_\_\_\_\_

TO \_\_\_\_\_

**ADDRESS CHANGE**

<b>Street Address</b>	
<b>City, State, Zip</b>	

**NAME OF INSURED:** \_\_\_\_\_  
(Please Print)

**PRODUCT TYPE:** \_\_\_\_\_  
(Group, Individual, Workers Life, Disability, Accident, Critical Illness, Other)

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

FOR INSURANCE COMPANY'S USE ONLY – ACKNOWLEDGEMENT OF CHANGE			
The recording of the change(s) requested above is hereby acknowledged.	Date Recorded	Policy Services Department	Initials