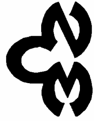

CHANGE OF BENEFICIARY and/or NAME FORM

Name of Insured ____
Last First M.I.

Policyholder Name ____

BENEFICIARY CHANGE

I hereby direct that the beneficiary changes noted below be applied to the following coverages:

☐ Group Short Term Disability Policy No. ______________________
☐ Group Long Term Disability Policy No. ______________________
☐ Group Term Life/AD&D Policy No. ______________________

Name of Primary Beneficiary ______________________________
Address ______________________________
Relationship ______________________________
Name of Contingent Beneficiary ______________________________
Address ______________________________
Relationship ______________________________

You may have the right to change your designated beneficiary. The written consent is needed of: 1) your spouse* if you are a resident of AZ, CA, ID, LA, NV, NM, TX, WA or WI and you name someone other than your spouse as beneficiary; and 2) any irrevocable beneficiary.

If more than one beneficiary is designated, payment of the death benefit will be made in equal shares to each of the beneficiaries who survive you, unless otherwise provided herein.

If none of Your designated beneficiaries survives You, payment will be made in accordance with the terms of the Policy.

NAME CHANGE

Change Name of: ☐ Insured ☐ Beneficiary ☐ Contingent Beneficiary

From: ____

To: ____

____ ______________________
Insured Signature Date

____ ______________________
* Spouse Signature Date