

CHANGE FORM

PLEASE PRINT & COMPLETE ONLY THE APPROPRIATE ITEMS

Policy Number	Email
Insured's Name	Social Security Number
Owner's Name	Social Security Number

1. **NAME CHANGE:** Change name of Insured Owner Payor Beneficiary

Print Former Name: _____ Signature: _____
(not required for Beneficiary)

Print New Name: _____ Signature: _____
(not required for Beneficiary)

Reason for Change: _____ Effective Date: _____
(If other than correction, attach a copy of legal evidence)

Address: _____ Phone # _____

2. **OWNERSHIP CHANGE:** Transfer ownership of the policy to:

Name: _____ Social Security # _____
 Address: _____ Phone # _____

Signature of New Owner: _____ Relationship to Insured: _____

3. **CHANGE OF BENEFICIARY:**

PRIMARY BENEFICIARY (IES) Equally, unless otherwise provided in percentages

Name: _____ % _____ **Social Security #** _____
 Address: _____
 Relationship: _____ Phone # _____ Birth Date _____

Name: _____ % _____ **Social Security #** _____
 Address: _____
 Relationship: _____ Phone # _____ Birth Date _____

CONTINGENT BENEFICIARY (IES) If no Primary Beneficiary survives the Insured, then,

Name: _____ % _____ **Social Security #** _____
 Address: _____
 Relationship: _____ Phone # _____ Birth Date _____

Name: _____ % _____ **Social Security #** _____
 Address: _____
 Relationship: _____ Phone # _____ Birth Date _____

4. **CERTIFICATE OF INSURANCE OR DUPLICATE POLICY:** I certify I have been unable to find the above-described policy and that it is not assigned or pledged. I request the issuance of a certificate of insurance, or duplicate policy, if available.

SIGNATURES: I/We agree that my/our signature(s) below shall apply to each request which has been checked.

_____	_____	_____	_____
Policy Owner	Date	Assignee Officers Signature	Date
_____	_____	_____	_____
Witness	Date	Assignee Title & Company	