

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	