REQUEST FOR CHANGE OF BENEFICIARY / NAME CHANGE FORM

Directions:

1. When completing the form, please avoid the use of the word "or" as it places the insurance company in the position of having to choose.

2. We recommend using percentages when naming more than one Primary or Contingent beneficiary. Please note that the Contingent beneficiary would receive the entire benefit if the Primary beneficiary is already deceased.

3. Please make sure that the person witnessing your signature is not a beneficiary of the policy, and that he/she is present when you sign the form.

4. After completing the form, please return it to the address on the form. Once we receive your form, it will be validated and a copy will be returned to you for your records.

Questions? Call 1-800-922-1245 Weekdays, 8am – 6pm Eastern Time
American Insurance Administrators, P. O. Box 1149, Columbus, OH 43216-1149

www.AlumniInsuranceProgram.com
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REQUEST FOR CHANGE OF BENEFICIARY / NAME CHANGE FORM

Group Policy Number: __________________ Certificate #: __________________
Insured: _________________________________________________________ Date of Birth: ______/______/________
Address: __________________________________________ City: __________________ State: _______ Zip________
Phone:________________ Email:_____________________________________ Soc. Sec.#: _______-_____-________

PRIMARY BENEFICIARY(S):

In accordance to the terms of the above policy, request is made for Change of Beneficiary to:
(Indicate Full Name and Relationship- Example: Jane Doe, Wife, and Not Mrs. John Doe)

Name: _______________________________________________________________ E Mail: _________________________________
Address: __________________________________________________________ ___ Date of Birth: ________/_______/____________
City/State/Zip __________________________________________________________ Social Security # ________/______/__________
Phone Number: _________________ Relationship: _________________________ Percentage: _____________________________

CONTINGENT BENEFICIARY(S):

Name: _______________________________________________________________ E Mail: _________________________________
Address: __________________________________________________________ ___ Date of Birth: ________/_______/____________
City/State/Zip __________________________________________________________ Social Security # ________/______/__________
Phone Number: _________________ Relationship: _________________________ Percentage: _____________________________

If surviving the Insured. Unless otherwise provided herein, if more than one beneficiary is named, payment shall be made in equal shares to the beneficiaries who survive the Insured; if no beneficiary survives the Insured, payment shall be made in accordance with the terms of the policy. The right to further change the beneficiary is reserved without the consent of the beneficiary.

CHANGE IN NAME ONLY OF: (   ) INSURED (   ) BENEFICIARY – changing name of person already named as beneficiary. Please do not use to change the beneficiary named.

Reason for change: ☐ Marriage ☐ By Court Order ☐ Divorce & resumption of Former Name

Former Name was: __________________________________________________________________________
Present Name is: __________________________________________________________________________
Date of qualifying event: _____________________________________________________________

In each case: Complete the Following Section

Note: This form must be signed by the Insured or Owner.

Insured’s
Signature: __________________________________________ City/State ________________ Date ____________
Witness: __________________________________________ City/State ________________ Date ____________
(SOMEONE OTHER THAN BENEFICIARY)

FOR INSURANCE COMPANY’S USE ONLY-ACKNOWLEDGEMENT OF CHANGE

The recording of the change(s) requested above is hereby acknowledged.

Date Recorded: ________________ By: __________________________________________

00-PS-343-F-Rev.11/13