CHUBB®

REQUEST FOR CHANGE OF NAMED BENEFICIARY: PLATINUM TERM 10 TO AGE 85

IMPORTANT: This policy is underwritten by Chubb Life Insurance Company of Canada ("Chubb Life")/Chubb du Canada Compagnie d'Assurance-Vie (« Chubb-Vie »). This Request affects only the Named Beneficiary of the Life Insurance Policy indicated below and does not affect any beneficiary designations on any other policies you may own. This request will not be effective if it is received by us after the death of the Insured.

Full Name of Insured	MR. ☐ MRS. ☐ MS. ☐ MISS ☐	Policy Number
First Middle Last		
Owner (If other than Insured)	MR. ☐ MRS. ☐ MS. ☐ MISS ☐	Form Number
First Middle Initial Last		

I hereby request Chubb Life/Chubb-Vie to pay the death benefit of the Life Insurance Policy indicated above to the Named Beneficiary indicated below. I hereby revoke all Prior Named Beneficiary designations.

LIFE INSURED 1 BENEFICIARY DESIGNATION

Beneficiary	Province	Date of Birth (MM/DD/YYYY)	% Share Must Equal 100%	Relationship to Life Insured 1	Revocable	Irrevocable
Name (First, Last)					☐ Initials	☐ Initials
Name (First, Last)					☐ Initials	☐ Initials

This section should be completed if the owner wishes to designate a contingent beneficiary in the event that there are no surviving beneficiaries when the death benefit becomes payable.

Contingent Beneficiary	Province	Date of Birth (MM/DD/YYYY)	% Share Must Equal 100%	Relationship to Life Insured 1	Revocable	Irrevocable
Name (First, Last)					☐ Initials	☐ Initials
Name (First, Last)					☐ Initials	☐ Initials

LIFE INSURED 2 BENEFICIARY DESIGNATION (if applicable)

Beneficiary	Province	Date of Birth (MM/DD/YYYY)	% Share Must Equal 100%	Relationship to Life Insured 2	Revocable	Irrevocable
Name (First, Last)					☐ Initials	☐ Initials
Name (First, Last)					☐ Initials	☐ Initials

This section should be completed if the owner wishes to designate a contingent beneficiary in the event that there are no surviving beneficiaries when the death benefit becomes payable.

Contingent Beneficiary	Province	Date of Birth (MM/DD/YYYY)	% Share Must Equal 100%	Relationship to Life Insured 2	Revocable	Irrevocable
Name (First, Last)					☐ Initials	☐ Initials
Name (First, Last)					☐ Initials	☐ Initials

Dated at_____ this_____ day of_____ 20____

Signature of Witness_____
print & sign name

Signature of Owner_____

Signature of Irrevocable Beneficiary (If Applicable)_____

FOR HEAD OFFICE USE ONLY
The Foregoing Request was Received on:_____ **By:**_____

Send this completed form to our Administrator at:
Combined Insurance Company of America / Compagnie d'assurance Combined d'Amérique
Canadian Head Office / Siège social canadien : P.O. Box 3720, MIP, Markham (Ontario) L3R 0X5
Telephone / Téléphone : 1 888 234-4466
www.combined.ca

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