



**CHANGE OF BENEFICIARY FORM**

In order to change your beneficiary, please provide the information requested below. Sign, date and return the form in the envelope provided. The beneficiary change requested only affects the insurance policy indicated below and no other policies you may own. We will send you a letter confirming the changes have been made to your policy.

BOX A  
POLICY NUMBER: \_\_\_\_\_

BOX B

	FIRST	MIDDLE	LAST
FULL NAME OF INSURED: _____			
<input type="checkbox"/> MR	<input type="checkbox"/> MRS	<input type="checkbox"/> MS	<input type="checkbox"/> MISS
	FIRST	MIDDLE	LAST
FULL NAME OF OWNER (IF NOT INSURED): _____			
<input type="checkbox"/> MR	<input type="checkbox"/> MRS	<input type="checkbox"/> MS	<input type="checkbox"/> MISS

**PLEASE READ THE FOLLOWING PARAGRAPH VERY CAREFULLY:**

In accordance with the Beneficiary provisions of the policy: I hereby request Combined Life Insurance Company of New York to pay the Death Benefit of the Insurance Policy indicated above to the named Beneficiaries below. I hereby revoke all prior named Beneficiary Designations.

BOX C	1st NAMED BENEFICIARY (FULL NAME)	RELATIONSHIP TO INSURED	DATE OF BIRTH
_____		_____	_____
ADDRESS (STREET/PO BOX / CITY / STATE / ZIP)		PRIMARY PHONE # <input type="checkbox"/> LANDLINE <input type="checkbox"/> MOBILE	SOCIAL SECURITY #
_____		_____	_____

If you name multiple beneficiaries *and do not check one of the options below*, the beneficiaries will share the Death Benefit equally.

BOX D	2nd NAMED BENEFICIARY (FULL NAME)	RELATIONSHIP TO INSURED	DATE OF BIRTH
(CHECK ONE: <input type="checkbox"/> Contingent or <input type="checkbox"/> Share Equally)		_____	_____
_____		_____	_____
ADDRESS (STREET/PO BOX / CITY / STATE / ZIP)		PRIMARY PHONE # <input type="checkbox"/> LANDLINE <input type="checkbox"/> MOBILE	SOCIAL SECURITY #
_____		_____	_____

**SIGNATURE OF POLICYOWNER:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

In accordance with the beneficiary provisions of the policy, I hereby request Combined Life Insurance Company of New York to pay the death benefit of the insurance policy above according to the beneficiary designations indicated and hereby revoke all prior named beneficiary designations.

**\*SIGNATURE OF POLICYOWNER'S SPOUSE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**\*Special Notice regarding Community Property:** Arizona, California, Idaho, Louisiana, New Mexico, Nevada, Texas, Washington, Wisconsin are community property states and Puerto Rico a community property territory. These laws may apply to this change request depending on your current marital status, marital status at the time of policy issuance, state where your policy was issued, residence state at time of issuance, and resident state(s) since issuance. Consult with your legal/tax advisor to determine if these laws apply to you and/or if you require a spousal signature on this form. **Combined Insurance disclaims any responsibility for determining the applicability of community property laws or the validity of the requested change.**

**\*\*SIGNATURE OF WITNESS (MA)** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**\*\*Special Notice regarding residents of Massachusetts:** State law requires that a disinterested adult who is not a party to the policy witness this request. If you reside in that state, this portion must be completed in order for this form to be accepted.