



Combined Insurance Company
Policyholder Service • Post Office Box 87208 • Chicago, IL 60680-0208 • www.combined.com

In order to change your beneficiary, please sign and date the form below in the presence of a witness. Have the witness also sign the form, and return it in the envelope provided. We will send you a confirmation letter to keep for your records once the change receives approval.

REQUEST FOR CHANGE OF NAMED BENEFICIARY

This request affects only the named beneficiaries of the Insurance policy indicated below. It does not affect any beneficiaries designated on other policies you may own.

Form with fields: FULL NAME OF INSURED __MR__MS__MISS__MRS and POLICY #

Form with field: OWNER __MR__MS__MISS__MRS

PLEASE READ THE FOLLOWING PARAGRAPH VERY CAREFULLY:

In accordance with the beneficiary provisions of the policy: I hereby request Combined Insurance Company of America to pay the death benefit of the insurance policy indicated above to the named beneficiaries below. I hereby revoke all prior named beneficiary designations.

Form with fields: 1st NAMED BENEFICIARY (FIRST /MIDDLE/LAST NAME) and RELATIONSHIP TO INSURED

Form with fields: STREET ADDRESS, CITY, STATE/ZIP CODE

If you name multiple beneficiaries and do not check one of the options below, the beneficiaries will share the death benefit equally.

Form with fields: 2nd NAMED BENEFICIARY (FIRST /MIDDLE/LAST NAME) (Please check one) [] Contingent or [] Share Equally and RELATIONSHIP TO INSURED

Form with fields: STREET ADDRESS, CITY, STATE/ZIP CODE

Dated at _____ this _____ day of _____ year

X _____
Signature of Witness

X _____
Signature of Owner:

X _____
Witness' Street Address City State/Zip Code