



Combined Insurance Company of America • Combined Life Insurance Company of New York
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.

(box A) FULL NAME OF INSURED __MR__MS__MISS__MRS	(box B) POLICY #
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(box C) 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.

(box D) 1 st NAMED BENEFICIARY (FIRST/MIDDLE/LAST NAME)	(box E) RELATIONSHIP TO INSURED
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(box F) STREET ADDRESS	CITY	STATE/ZIP CODE
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If you name multiple beneficiaries *and do not check one of the options below*, the beneficiaries will share the death benefit equally.

(box G) 2 nd NAMED BENEFICIARY (FIRST/MIDDLE/LAST NAME) (Please check one) <input type="checkbox"/> Contingent or <input type="checkbox"/> Share Equally	(box H) RELATIONSHIP TO INSURED
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(box I) STREET ADDRESS	CITY	STATE/ZIP CODE
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Dated at _____ month of _____ this _____ day of _____ year

X _____
Signature of Witness (in the presence of Policy Owner)

X _____
Signature of Policy Owner

X _____
Witness' Street Address

X _____
*Signature of Policy Owner's Spouse

X _____
Witness' City, State, Zip

***Signature of Spouse REQUIRED in Arizona, California, Idaho, Louisiana, New Mexico, Nevada, Texas, Washington, Wisconsin and Puerto Rico**