



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.

FULL NAME OF INSURED \_\_MR\_\_MS\_\_MISS\_\_MRS POLICY #

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.

1st NAMED BENEFICIARY (FIRST /MIDDLE/LAST NAME) RELATIONSHIP TO INSURED

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.

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

STREET ADDRESS CITY STATE/ZIP CODE

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ year

X \_\_\_\_\_
Signature of Witness

X \_\_\_\_\_
Signature of Owner:

X \_\_\_\_\_
Witness' Street Address

X \_\_\_\_\_
\*Spouse's Signature

\_\_\_\_\_  
City State/Zip Code

\*Signature of Spouse REQUIRED in Puerto Rico