GROUP INSURANCE CERTIFICATE CHANGE FORM

See Instructions on Reverse

BOSTON MUTUAL LIFE INSURANCE COMPANY • 120 ROYALL STREET • CANTON, MASSACHUSETTS 02021-9968 • (800) 669-2668

GROUP NUMBER	DIVISION NUMBER	EMPLOYER (POLICYHOLDER) NAME

EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL)

CERTIFICATE #

UNDER THE TERMS OF THE ABOVE POLICY(IES) I HEREBY REQUEST BOSTON MUTUAL LIFE INSURANCE COMPANY TO:

☐ **CHANGE OF BENEFICIARY**

Primary Beneficiary(ies)	Residential Address	Date of Birth	Social Security #	Tele. #	Relationship	% of Benefit
Contingent Beneficiary(ies)	**Residential Address**	**Date of Birth**	**Social Security #**	**Tele. #**	**Relationship**	**% of Benefit**

☐ **CHANGE OF NAME**

To: _____

I hereby agree that the copy of the signature appearing on the carbon copy of this form shall be accepted as my signature and I further agree to the conditions appearing on the reverse side hereof.

☐ **ISSUE DUPLICATE CERTIFICATE (POLICY)** because my original certificate (policy) has been lost or mislaid. I declare that such original certificate (policy) has not been pledged as security for any loan and that I do not know where such certificate (policy) is now. If such certificate (policy) is found I will surrender it to the Insurance Company immediately.

POLICYHOLDER'S ACKNOWLEDGEMENT OF CHANGE
THE AUTHORIZED CHANGE(S) SET FORTH IN THE FOREGOING INSTRUMENT ARE HEREBY ACKNOWLEDGED.

Insured's Signature

Date

Administrator's Authorized Signature

Date

Administrator's Copy
Attach to
Enrollment Card

G-501

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