

**ORIGINAL  
TO NABCO**



# NORTH AMERICAN BENEFITS COMPANY

CERT. NO.	POLICY NUMBER
COMPANY USE	

## GROUP INSURANCE CHANGE FORM (For Name or Beneficiary Change)

INSURED'S LAST NAME

FIRST NAME

MIDDLE INITIAL

NAME OF EMPLOYER

INSURED'S FORMER NAME

CHANGE TO

LAST NAME

FIRST NAME

MIDDLE INITIAL

AGE

RELATIONSHIP TO EMPLOYEE

Primary \_\_\_\_\_

Contingent \_\_\_\_\_

Your benefits will be paid first to the Primary beneficiary(ies). If that person(s) is deceased, benefits will be paid to the Contingent beneficiary(ies). (Legal appointment of guardian is required if minor is named as beneficiary.) If no beneficiary survives, payment shall be made in accordance with the terms of the policy.

Any previous beneficiary is hereby revoked. The right is reserved to change this designation. No change of beneficiary will take effect until this request has been recorded at the office where records are maintained.

\_\_\_\_\_  
Date Signed by Insured

\_\_\_\_\_  
Signature of Insured

\_\_\_\_\_  
Social Security Number

**NAME CHANGE**

**BENEFICIARY  
CHANGE**

**PLEASE READ, DATE  
AND SIGN.**

**ONE COPY  
TO EMPLOYEE  
ONE COPY  
TO POLICYHOLDER**