

BENEFICIARY CHANGE FORM

CHUBB®

Administrative Office:
PO Box 506
Keene NH 03431-0506

A. Coverage Information

Certificate Number: _____ Name of Insured: _____

Name of Certificateholder(s) Social Security or TIN No. (include dashes) Daytime Telephone No.

Address

City State Zip Code

B. Beneficiary Changes. *Please include the address and Social Security Number of beneficiary(s)*

___ Change Beneficiary(ies).

I hereby revoke any and all prior beneficiary designations and existing settlement agreements, if any, and elect to change the beneficiary(ies) under the above numbered certificate as follows:

Primary Beneficiary(ies): For multiple beneficiaries, payment will be made in equal share unless otherwise stated below.

Full Name (as it should appear on Company records) % Address (including City/State/Zip) Relationship Date of Birth Social Security #

Contingent Beneficiary(ies): For multiple beneficiaries, payment will be made in equal share unless otherwise stated below.

Full Name (as it should appear on Company records) % Address (including City/State/Zip) Relationship Date of Birth Social Security #

It is understood and agreed that, unless otherwise directed, proceeds will be paid in accordance with the certificate provisions.

C. Signatures.

Certificateholder's Signature

Date

Spouse
(req. in community property states)

Date

Irrevocable Beneficiary's Signature

Date

Assignee's Signature

Date