

# 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
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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 \_\_\_\_\_

Administrator's Authorized Signature \_\_\_\_\_

Administrator's Copy  
Attach to  
Enrollment Card

Date \_\_\_\_\_

Date \_\_\_\_\_