COMBINED INSURANCE

BENEFICIARY CHANGE FORM

Administered by: Vision Financial Corporation
PO Box 506
Keene NH 03431-0506

A. Coverage Information

Certificate Number: _____ Name of Insured: _____

_____

Name of Certificate Holder(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), if known*

☐ 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*

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*

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

C. Signatures.

_____ _____ _____ _____
Certificate Holder's Signature Date Spouse *(req. in community property states)* Date

_____ _____ _____ _____
Irrevocable Beneficiary's Signature Date Assignee's Signature Date