ORIGINAL
TO **COMPANY**

ONE COPY
TO **EMPLOYEE**

ONE COPY
TO **POLICYHOLDER**

4 EVER
LIFE INSURANCE 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 MY EMPLOYER

NAME CHANGE

INSURED'S FORMER NAME

CHANGE TO

BENEFICIARY CHANGE

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.

PLEASE READ, DATE AND SIGN.

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

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Social Security Number

Form 1.553 08/2011