



FRATERNAL INSURANCE BENEFITS

24950 Country Club Blvd., Suite 340
North Olmsted, Ohio 44070-5333
Phone 216-228-9400 www.utuia.org

CHANGE OF BENEFICIARY REQUEST

For approval and endorsement, this request must be correctly completed, signed, dated and witnessed by a disinterested party. No faxes or photocopies will be accepted in place of the original document. If additional space is required, you may submit additional names on a separate sheet of paper as long as the necessary information outlined below is provided.

Owner _____ Social Security No. _____

Insured ICppwkcqv' _____ 'Social Security No. _____

Policy(ies) No. _____

PRIMARY BENEFICIARY: A primary beneficiary is a person or institution which will be paid the proceeds of your policy in the event of your death. Do not name yourself as a beneficiary. The combined percentage for all primary beneficiaries must equal 100%. Please print clearly.

Primary Beneficiary Name		Street Address	
City, State, Zip			Date of Birth
Percentage	Social Security Number	Telephone Number	Relationship to Insured

Primary Beneficiary Name		Street Address	
City, State, Zip			Date of Birth
Percentage	Social Security Number	Telephone Number	Relationship to Insured

Primary Beneficiary Name		Street Address	
City, State, Zip			Date of Birth
Percentage	Social Security Number	Telephone Number	Relationship to Insured

Primary Beneficiary Name		Street Address	
City, State, Zip			Date of Birth
Percentage	Social Security Number	Telephone Number	Relationship to Insured

CONTINGENT BENEFICIARY: A contingent beneficiary is a person or institution which will be paid the proceeds of your policy if no primary beneficiaries are living or in existence at the time of your death. Do not name yourself or any primary beneficiary as a contingent beneficiary. The combined percentage for all contingent beneficiaries must equal 100%. Please print clearly.

Contingent Beneficiary Name		Street Address	
City, State, Zip			Date of Birth
Percentage	Social Security Number	Telephone Number	Relationship to Insured

Contingent Beneficiary Name		Street Address	
City, State, Zip			Date of Birth
Percentage	Social Security Number	Telephone Number	Relationship to Insured

Contingent Beneficiary Name		Street Address	
City, State, Zip			Date of Birth
Percentage	Social Security Number	Telephone Number	Relationship to Insured

Contingent Beneficiary Name		Street Address	
City, State, Zip			Date of Birth
Percentage	Social Security Number	Telephone Number	Relationship to Insured

Signature of Owner

Street Address/City/State/Zip

Signature of Witness (Not a named Beneficiary)

Telephone Number

Date

(DO NOT WRITE IN THIS AREA - FOR UTUIA OFFICE USE ONLY)

The beneficiaries of the policy(ies) is/are hereby changed to be consistent with this request. All prior beneficiary designations are revoked.

Dated: _____

Secretary and Treasurer