



**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 _____