Tangipahoa Parish Schools
Group # 9857 48241

CHUBB®

BENEFICIARY CHANGE FORM

Administrative Office:
PO Box 506
Keene NH 03431-0506

A. Coverage Information

Certificate Number: _____ Name of Insured: _____

_____

Name of Certificateholder(s) Social Security or TIN No. (include dashes) Daytime Telephone No.

_____

Address

LA

_____

City State Zip Code

B. Beneficiary Changes. *Please include the address and Social Security Number of beneficiary(s)*

__ 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*	*Social Security #*

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*	*Social Security #*

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

C. Signatures.

Certificateholder's Signature	Date	Spouse *(req. in community property states)*	Date
Irrevocable Beneficiary's Signature	Date	Assignee's Signature	Date