

# GROUP INSURANCE CERTIFICATE CHANGE FORM

See Instructions on Reverse

BOSTON MUTUAL LIFE INSURANCE COMPANY • 120 ROYALL STREET • CANTON, MASSACHUSETTS 02021-9968 • (800) 669-2668

GROUP NUMBER	DIVISION NUMBER	EMPLOYER (POLICYHOLDER) NAME
EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL)		CERTIFICATE #

UNDER THE TERMS OF THE ABOVE POLICY(IES) I HEREBY REQUEST BOSTON MUTUAL LIFE INSURANCE COMPANY TO:

**CHANGE OF BENEFICIARY**

Primary Beneficiary(ies)	Residential Address	Date of Birth	Social Security #	Tele. #	Relationship	% of Benefit
Contingent Beneficiary(ies)	Residential Address	Date of Birth	Social Security #	Tele. #	Relationship	% of Benefit

**CHANGE OF NAME**

To: \_\_\_\_\_

**ISSUE DUPLICATE CERTIFICATE (POLICY)** because my original certificate (policy) has been lost or mislaid. I declare that such original certificate (policy) has not been pledged as security for any loan and that I do not know where such certificate (policy) is now. If such certificate (policy) is found I will surrender it to the Insurance Company immediately.

I hereby agree that the copy of the signature appearing on the carbon copy of this form shall be accepted as my signature and I further agree to the conditions appearing on the reverse side hereof.

POLICYHOLDER'S ACKNOWLEDGEMENT OF CHANGE  
THE AUTHORIZED CHANGE(S) SET FORTH IN THE FOREGOING  
INSTRUMENT ARE HEREBY ACKNOWLEDGED.

Insured's Signature	Administrator's Authorized Signature	
Date	Date	Administrator's Copy Attach to Enrollment Card