

PLAN ADMINISTRATION, LTD
CHANGE REQUEST TO BE COMPLETED BY EMPLOYEE

Please print

EMPLOYEE'S NAME: As it now appears on PAL records			SOCIAL SECURITY NUMBER
LAST	FIRST	MIDDLE INITIAL	GROUP NUMBER
EMPLOYER			GROUP NUMBER

CHANGE OF BENEFICIARY: This designation replaces any other beneficiary designation I may have previously made for my insurance under the Group Policy. (Unless otherwise noted, if two or more beneficiaries are named, proceeds will be paid in equal shares to the named beneficiaries who survive the insured.)

First Name	Last Name	Social Security #	Date of Birth	Relationship	Benefit %
Primary					
Primary					
Contingent					
Contingent					

CHANGE MY NAME TO: _____ EFFECTIVE DATE OF CHANGE _____

Reason: Marriage Divorce Other _____

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

DATE SIGNED _____

EMPLOYEE'S SIGNATURE: _____