

BENEFICIARY CHANGE FORM

CHUBB®

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

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*

Date

Irrevocable Beneficiary's Signature

Date

Assignee's Signature

Date

*SPOUSE MUST SIGN BENEFICIARY CHANGE FORM IF RESIDENT OF COMMUNITY PROPERTY STATE: AZ; CA; ID; LA; NV; NM; TX; WA; WI