Change of Beneficiary Request Form

Beneficiary change requests can only be made during the lifetime of the insured. Upon the Insurer's receipt of this completed form, the Beneficiary change will be effective as of the date it was signed by the Policyowner and whether or not the Insured is living when we receive it. However, the change will be subject to any payment that the Insurer may have made or actions it may have taken prior to receipt of the completed form.

Contact Information:
Clients
Call 1-800-231-5453
Fax
Call 1-888-568-9705

Important Instructions

1. If new beneficiary is a trust, a copy of the trust document must be submitted and the trust name and date must be included as the name in the information box below.
2. If additional space is needed, please attach a separate sheet which includes: 1) the policy number and name of insured; 2) the information requested in the box below; 3) signature of Owner(s) along with the date; and 4) the signature of a Witness.
3. For multiple beneficiaries, use percentages NOT dollar amounts. If no percentages are indicated, an equal division is assumed.

Section A - Policy information (you must complete this section)

Policy Number	Insured's Name	Policyowner's Name

Section B - Primary beneficiary information

Primary – The undersigned hereby requests that all previous primary beneficiary designations and settlement options elected be revoked and makes the following designations (if no entry is made, previous designations and/or elections will remain unchanged):

Name	Social Security Number	Date of Birth		Relationship to Insured	Percentage
Address	City	State	Zip Code	Phone Number	
Name	Social Security Number	Date of Birth		Relationship to Insured	Percentage
Address	City	State	Zip Code	Phone Number	
Name	Social Security Number	Date of Birth		Relationship to Insured	Percentage
Address	City	State	Zip Code	Phone Number	

Section C - Contingent beneficiary information

Contingent (secondary) – *Receives benefits ONLY if no Primary Beneficiary survives the insured.* The undersigned hereby requests that all previous contingent beneficiary designations and settlement options elected be revoked and makes the following designations (if no entry is made, previous designations and/or elections will remain unchanged):

Name	Social Security Number	Date of Birth		Relationship to Insured	Percentage
Address	City	State	Zip Code	Phone Number	
Name	Social Security Number	Date of Birth		Relationship to Insured	Percentage
Address	City	State	Zip Code	Phone Number	
Name	Social Security Number	Date of Birth		Relationship to Insured	Percentage
Address	City	State	Zip Code	Phone Number	

Section D - Signatures (you must complete this section)

Signature of Policyowner (with title if applicable)	Policyowner's Telephone Number	Date (mm/dd/yyyy)
Signature of Co-owner (with title if applicable) or Second Officer with title (if corporate-owned)		Date (mm/dd/yyyy)
Signature of Witness (person cannot be a designated Beneficiary)	Name of Witness (Please Print)	Date (mm/dd/yyyy)

Have you...

- completed Section A and provided us with complete Policyowner information?
- provided us with complete Primary beneficiary information in Section B?
- provided us with complete Contingent beneficiary information in Section C, if applicable?
- completed Section D by providing us with all appropriate signatures and dates?

For standard mail delivery:
The Hartford
Individual Life Division
PO Box 64582
St. Paul, MN 55164-0582