

**BENEFICIARY
CHANGE FORM**



Established 1896

Administered by: Vision Financial Corporation
PO Box 506
Keene NH 03431-0506

A. Coverage Information

Certificate Number: _____ Name of Insured: _____

Name of Owner(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), if known*

___ 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

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

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

C. Signatures.

Owner's Signature Date Spouse (req. in community property states) Date

Irrevocable Beneficiary's Signature Date