120 ROYALL STREET CANTON, MASSACHUSETTS 02021 TEL (877) 624-2249 (781) 828-7000 FAX (781) 770-0490

BOSTON MUTUAL LIFE INSURANCE COMPANY - 1891 -

CLIENT SERVICES DEPARTMENT

Dear Policyholder:

We have received your request for policy change. **Please complete the appropriate section and mail or fax to the address or fax number noted above.** If you have any questions please call our Client Services Department (877) 624-2249.

As owner of the policy(ies) noted below, I authorize you to make the following changes as indicated:

POLICY #: INSURED:

☐ **NAME CHANGE** ☐ Insured ☐ Payor ☐ Beneficiary ☐ Owner

(Do not use this form to designate a new beneficiary or owner.)

FORMER NAME: _____ NEW NAME: _____

Reason for Change:_____

(Please Note: If other than for a spelling error or for Marriage or Divorce – you must provide proof of the change.)

☐ **ADDRESS CHANGE** ☐ Insured ☐ Payor ☐ Beneficiary ☐ Owner ☐ Employer (List Bill)

NEW RESIDENTIAL ADDRESS: _____

NEW MAILING ADDRESS: _____

☐ **SOCIAL SECURITY NUMBER CORRECTION:**

(For policyowner only. Social Security Number for individuals, Corporate Tax I.D. Number for companies.)

OWNER'S NAME: _____ CORRECTED SSN: _____

Reason for Change:_____ *(Requires proof of the corrected SSN)*

☐ **LOST POLICY CERTIFICATE REQUEST**

☐ **DUPLICATE POLICY REQUEST** **(THERE IS A $ 10.00 CHARGE FOR A DUPLICATE POLICY WHICH MUST ACCOMPANY YOUR REQUEST)**

- ☐ I have made a persistent search for this policy, but have no knowledge of its whereabouts.
- ☐ My policy is unobtainable at this time, but I agree to send it to Boston Mutual if and when it is located

Please complete this section with all appropriate signatures and information. Missing data may delay processing.

_____ DATE

_____ OWNER NAME

_____ AGENT/WITNESS SIGNATURE

_____ OWNER SIGNATURE

(_____) _____-_____ TELEPHONE NUMBER

___XXX / XX / _____ OWNER SOCIAL SECURITY NUMBER

_____ RESIDENTIAL ADDRESS