



FAMILY MATTERS. NO MATTER WHAT®

CHANGE OF BENEFICIARY FORM-CLIENT SERVICED DEPARTMENT

Thank you for being a valued Boston Mutual Life Insurance customer. **Please review the following instructions carefully prior to completing the attached Change of Beneficiary form. Please turn your form into the Treasurer's Office or School Administration Office**

1. Please use the attached form to change the beneficiary on insurance policies and annuity contracts owned by you. Use a separate form for each policy you wish to change.
2. Please use complete names (John J. Smith, **not** J. J. Smith.), and use a married woman's own name (Mary S. Jones, **not** Mrs. John Jones).
3. If it is your intent to designate all children born to or adopted by the Insured, please state, "All Children". However if you wish to designate a specific child(ren) only, list the full name and date of birth for each child to be designated as a beneficiary. Future children will not automatically be considered as a beneficiary with this designation.
4. Fill in current addresses and Tax Identification numbers for all beneficiaries. Please use Social Security #'s for individuals. The last four positions of the Social Security # of the beneficiaries are sufficient. Use the full Federal Tax I.D. for business entities.
5. **OPTIONAL PROVISIONS.** Check either or both of these as desired. Please do not check **Payment to Lawful Descendants Of Deceased Children** box unless the Insured's children are designated as beneficiaries.
6. The **spouse** of the owner must also sign if any policy was issued in a **community property state. (CA, ID, NV, NM, WA, or WI.** Also in **LA**, but **ONLY** if the new owner will be "The Estate".) If the spouse is dead, a death certificate is required. If there has been a divorce, please furnish a certified copy of the divorce decree **and** property settlement agreement.
7. If a Trust is designated as beneficiary, please use the following format:
The Blank National Bank of Boston, Massachusetts, as Trustee, under Agreement of Trust dated _____, or, John Jones as Trustee, under Agreement of Trust dated _____.
8. If you wish to name more than 2 Primary beneficiaries or 2 Contingent beneficiary, please continue on a piece of plain paper, listing the same information requested on this form. Please sign and date the additional page in the same manner as the original form.
9. **Mail or fax the completed form to the address or fax number noted below.** A recorded copy will be returned to be attached to your policy or annuity.

IMPORTANT NOTICE – PLEASE READ

We strongly urge that you thoughtfully consider any change of beneficiary. For example, many of our clients will name a minor child as the primary beneficiary, not realizing the consequences. If the child has not reached the age of majority at the time of the claim, he or she cannot give a valid release and we are therefore forced to hold up payment of the proceeds until the court appoints a legal guardian. As a result, the immediate benefits to the child could be delayed for some time.

To avoid delays, please be sure that this form is completed fully and legibly, and signed by all necessary parties:

- **The policyowner in all cases.**
- **The current beneficiary if designated as irrevocable; or, if the policy was issued prior to 1/1/1948.**
- **If the owner resides in Massachusetts, the signature of a disinterested adult witness is required.**
- **In all other states, a witness signature is not required but is strongly recommended.**
- **The spouse in a community property state.**

CHANGE OF BENEFICIARY FORM

Policy#: _____

Insured Name: _____

As owner of the Policy noted above, I hereby revoke prior beneficiary designation(s) and any special settlement agreement(s), and name as the new beneficiary or beneficiaries the following: ***Please complete as much of the following as possible. This information assists us in locating your beneficiary.***

PRIMARY BENEFICIARY _____% ** see <u>NOTE</u>	Name	Relationship	Date of Birth (MO/DAY/YR)
	Address (Residential address & mailing if different from residential)		Telephone
			Social Security # (if possible, provide full) XXX_ - XX_ - _____
PRIMARY BENEFICIARY _____% ** see <u>NOTE</u>	Name	Relationship	Date of Birth (MO/DAY/YR)
	Address (Residential address & mailing if different from residential)		Telephone
			Social Security # (if possible, provide full) XXX_ - XX_ - _____

****NOTE:** The percentages allocated to all named Primary Beneficiaries must total 100%. Refer to General Provision #1 below.

CONTINGENT BENEFICIARY _____% ** see <u>NOTE</u>	Name	Relationship	Date of Birth (MO/DAY/YR)
	Address (Residential address & mailing if different from residential)		Telephone
			Social Security # (if possible, provide full) XXX_ - XX_ - _____
CONTINGENT BENEFICIARY _____% ** see <u>NOTE</u>	Name	Relationship	Date of Birth (MO/DAY/YR)
	Address (Residential address & mailing if different from residential)		Telephone
			Social Security # (if possible, provide full) XXX_ - XX_ - _____

****NOTE:** The percentages allocated to all named Contingent Beneficiaries must total 100%. Refer to General Provision #2 below.

OPTIONAL PROVISIONS (Applicable to Primary Beneficiary and Contingent Beneficiary, if any)

- Short Term Survivorship.** If any beneficiary dies simultaneously with the Insured or within 30 days after the Insured's death, such beneficiary shall be deemed for all purposes hereof not to have survived the Insured.
- Payment To Lawful Descendants Of Deceased Children.** If any child of the Insured does not survive the Insured, that share shall be paid to his or her lawful descendants by right of representation: and if none, in equal shares to any other lawful surviving children of the Insured, the lawful descendants of any child not surviving the Insured taking such deceased child's share by right of representation.

GENERAL PROVISIONS

Unless specified otherwise, and subject to any elected Optional Provision:

1. Payment will be made to the **Primary** beneficiary or beneficiaries who shall survive the Insured, **in equal shares**, or in specified percentages. Specific amounts may not be designated.
2. If no primary beneficiary survives, payment will be made to the **Contingent** beneficiary or beneficiaries who shall survive the Insured, in equal shares or in specified percentages. Specific amounts may not be designated.
3. If none of the beneficiaries shall survive the Insured, payment will be made to the Insured's estate.
4. If a **Trust** is designated as beneficiary, it is agreed that the Company shall not be bound by any trust, deed, or partnership agreement and shall not be liable in any way for the application of the proceeds of the policy by a Trustee beneficiary or other person. It is further agreed that if a trust is designated as beneficiary, and if said trust fails for any reason, or if no trustee is appointed within one year after the death of the Insured, then the policy proceeds will be paid in one sum to the estate of the Insured. Payment of any proceeds to any herein named trustee or trustees shall fully and finally discharge the Company from all liability.

This change of beneficiary will take effect when recorded by the Company at its Home Office only if the policy or annuity is in force or is being continued under a nonforfeiture option on the date of this request. After recording, this change of beneficiary will relate back and take effect as of the date of this request, without prejudice to any payments made by the Company before recording. The Company waives its right of endorsement on the policy.

I reserve the right to change the beneficiary hereunder, subject to all the provisions of said policy and subject to any pledge or assignment thereof. No proceedings in bankruptcy or insolvency, voluntary or involuntary, are pending against the undersigned, nor is the undersigned under guardianship or any other legal disability.

I appoint the above named Beneficiary(ies) as my Authorized Representative for the purpose of obtaining medical records in order to facilitate the payment of my life insurance benefits. This authorization is valid from the date of my death for a period of 12 months.

Social Security Number or Last 4 Digits

Signature of Policyowner

Date

Signature of Witness other than Beneficiary
(Required in Massachusetts, Strongly suggested in all other states)

Signature of Spouse (If policy was issued in a Community Property State)

****Please Note: The form will be returned if the signature is over 30 days from the date we receive it****

This beneficiary designation has been recorded at the Home Office of BOSTON MUTUAL LIFE INSURANCE COMPANY

Date Recorded: _____

By: _____
Secretary