GROUP INSURANCE CERTIFICATE CHANGE FORM

See Instructions on Reverse

BOSTON MUTUAL LIFE INSURANCE COMPANY • 120 ROYALL STREET • CANTON, MASSACHUSETTS 02021-9968 • (800) 669-2668

GROUP NUMBER	DIVISION NUMBER	EMPLOYER (POLICYHOLDER) NAME
G-26673		Wachusett Regional School District

EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL)

CERTIFICATE #

UNDER THE TERMS OF THE ABOVE POLICY(IES) I HEREBY REQUEST BOSTON MUTUAL LIFE INSURANCE COMPANY TO:

☐ CHANGE OF BENEFICIARY

Primary Beneficiary(ies)	Residential Address	Date of Birth	Social Security #	Tele. #	Relationship	% of Benefit

Contingent Beneficiary(ies)	Residential Address	Date of Birth	Social Security #	Tele. #	Relationship	% of Benefit

☐ CHANGE OF NAME

To: ______________________________

☐ **ISSUE DUPLICATE CERTIFICATE (POLICY)** because my original certificate (policy) has been lost or mislaid. I declare that such original certificate (policy) has not been pledged as security for any loan and that I do not know where such certificate (policy) is now. If such certificate (policy) is found I will surrender it to the Insurance Company immediately.

I hereby agree that the copy of the signature appearing on the carbon copy of this form shall be accepted as my signature and I further agree to the conditions appearing on the reverse side hereof.

POLICYHOLDER'S ACKNOWLEDGEMENT OF CHANGE
THE AUTHORIZED CHANGE(S) SET FORTH IN THE FOREGOING INSTRUMENT ARE HEREBY ACKNOWLEDGED.

____
Insured's Signature

____
Administrator's Authorized Signature

Administrator's Copy
Attach to
Enrollment Card

____
Date

____
Date

G-501

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