Change of Beneficiary

P.O. Box 64582
St. Paul, MN 55164-0582
(800) 231-5453
Fax: (651) 738-5629

____
Policy Number

____
Name of Insured

____
Policyowner's Name

Beneficiary change requests can only be made during the lifetime of the insured. Upon Hartford'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 Hartford may have made or actions it may have taken prior to receipt of the completed form.

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; and 3) signature of Owner(s) along with the date.
3. For multiple beneficiaries, use percentages NOT dollar amounts.

Primary – The undersigned hereby requests that all previous primary beneficiary designations and settlement options elected be revoked and makes the following designations:

Name		Name		Name	
Address		Address		Address	
Relationship	%	Relationship	%	Relationship	%
Social Security Number		Social Security Number		Social Security Number	

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:

Name		Name		Name	
Address		Address		Address	
Relationship	%	Relationship	%	Relationship	%
Social Security Number		Social Security Number		Social Security Number	

______________________________ ______________________________
Signature of Policyowner (with title if applicable) Date

______________________________ ______________________________
Signature of Co-owner (with title if applicable) or Second Officer with title (if corporate-owned) Date

______________________________ ______________________________
Policyowner's Telephone Number Social Security or Tax ID number