



The Company You Keep®



Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Financial Institution Name: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Certificate Number: \_\_\_\_\_

**Change Form Accidental Death & Dismemberment Insurance**

**1. Please change amount of Additional Coverage to:**

Individual	Family		Individual	Family		Individual	Family		Individual	Family	
<input type="checkbox"/>	<input type="checkbox"/>	\$10,000	<input type="checkbox"/>	<input type="checkbox"/>	\$40,000	<input type="checkbox"/>	<input type="checkbox"/>	\$80,000	<input type="checkbox"/>	<input type="checkbox"/>	\$150,000
<input type="checkbox"/>	<input type="checkbox"/>	\$20,000	<input type="checkbox"/>	<input type="checkbox"/>	\$50,000	<input type="checkbox"/>	<input type="checkbox"/>	\$90,000	<input type="checkbox"/>	<input type="checkbox"/>	\$200,000
<input type="checkbox"/>	<input type="checkbox"/>	\$30,000	<input type="checkbox"/>	<input type="checkbox"/>	\$60,000	<input type="checkbox"/>	<input type="checkbox"/>	\$100,000	<input type="checkbox"/>	<input type="checkbox"/>	\$250,000
<input type="checkbox"/>	<input type="checkbox"/>	Other									

\*All Coverage amounts reduce to 50% when insured reaches age 70 and to 25% at age 75.

**2. I want to:**

- Cancel all Coverage
- Cancel Additional Coverage (Basic Coverage remains in effect)
- Cancel Family Coverage (Leaves Individual Coverage in effect)
- Add Family Coverage

**3. Change (do NOT complete if requesting only a Change in Beneficiary)**

I hereby request that the records kept in connection with the group policy reflect the following change:

A Copy of a marriage certificate, divorce decree or other court or official document is required to change an insured owner's name.

- My Name From: \_\_\_\_\_ To: \_\_\_\_\_
- Beneficiary Name From: \_\_\_\_\_ To: \_\_\_\_\_
- My Address From: \_\_\_\_\_ To: \_\_\_\_\_
- Beneficiary Address From: \_\_\_\_\_ To: \_\_\_\_\_
- Account From: \_\_\_\_\_ To: \_\_\_\_\_
  - Checking
  - Savings

**ABA#**

**4. Change Beneficiary to:**

I hereby designate the person or persons below as beneficiary for my individual insurance, revoking any other beneficiary designation and optional method of settlement election for such insurance, such change to be effective in accordance with the terms and conditions of the group policy.

NAME	SOCIAL SECURITY #	RELATIONSHIP	ADDRESS	PERCENTAGE
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**Insured's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Recorded on behalf of New York Life, subject to the terms and conditions of the group policy:

By \_\_\_\_\_ Date: \_\_\_\_\_

(NBFS 06/2017)

**Please retain a copy of this request for your files and return to:**  
NBFS, P.O. Box 24279, Winston Salem, NC 27114-4279 or email to [customerservice@nbfsa.com](mailto:customerservice@nbfsa.com)