

**BENEFICIARY  
CHANGE FORM**



Established 1896

Administered by: Vision Financial Corporation  
PO Box 506  
Keene NH 03431-0506

**A. Coverage Information**

Certificate Number: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

\_\_\_\_\_  
Name of Certificate Holder(s) Social Security or TIN No. (include dashes) Daytime Telephone No.

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip Code

**B. Beneficiary Changes.** *Please include the address and Social Security Number of beneficiary(s), if known*

\_\_\_ Change Beneficiary(ies).

I hereby revoke any and all prior beneficiary designations and existing settlement agreements, if any, and elect to change the beneficiary(ies) under the above numbered certificate as follows:

**Primary Beneficiary(ies):** For multiple beneficiaries, payment will be made in equal share unless otherwise stated below.  
Full Name (as it should appear on Company records) % Address (including City/State/Zip) Relationship Date of Birth

**Contingent Beneficiary(ies):** For multiple beneficiaries, payment will be made in equal share unless otherwise stated below.  
Full Name (as it should appear on Company records) % Address (including City/State/Zip) Relationship Date of Birth

It is understood and agreed that, unless otherwise directed, proceeds will be paid in accordance with the certificate provisions.

**C. Signatures.**

\_\_\_\_\_  
Certificate Holder's Signature Date Spouse (req. in community property states) Date

\_\_\_\_\_  
Irrevocable Beneficiary's Signature Date Assignee's Signature Date