



**Employees' Mutual Benefit Association
Short Term Disability Insurance Policy**

REQUEST FOR CHANGE OF BENEFICIARY

I hereby request that the beneficiary on my policy be changed as follows:

Name: _____

Relationship to Insured: _____

Full Address: _____

Contingent Beneficiary: _____

Relationship to Insured: _____

Full Address: _____

Effective Date of Change: _____

I understand that this change in beneficiary designation revokes any prior beneficiary designation.

Signature of Insured

Full Address

Phone Number

Employee ID Number