WELLFLEET
WORKPLACE

CHANGE OF NAME AND/OR BENEFICIARY FORM

Submitting your form

Submit your form the way you like. Mail, email or fax it to:

Wellfleet Insurance Company
P.O. Box 15769
Springfield, MA 01115
Fax: 413-452-5486
Email: workplaceclaims@wellfleetinsurance.com

Helpful reminders

- Please complete all sections of this form by typing on a computer or printing and filling in with ballpoint pen.
- Note that the form must be completed in full, dated and properly signed in the presence of a witness.
- No erasures or alterations are permitted. If an error is made, please complete a new form.
- The insured's name must be printed exactly as it is currently shown on the insurance records.
- In naming a beneficiary, make sure to word the designation carefully and include the date of birth ("d.o.b.").

Suggested wording for common benefit designations

The examples below represent the most common designations and may be used as applicable.

- **One beneficiary**: Mary E. Doe (d.o.b. 3/20/70), wife.
  - Note: A married woman *should not* be shown as "Mrs. John H. Doe"; instead, she should go by her legal name.
- **Two beneficiaries in equal amounts**: Robert H. Doe (d.o.b. 4/4/48), father; and Carol A. Doe (d.o.b. 6/10/50), mother; equally or to the survivor.
- **Three or more beneficiaries in equal amounts**: James F. Doe (d.o.b. 5/18/94), Thomas A. Doe (d.o.b.7/12/93), and Susan M. Doe (d.o.b. 12/20/92); children of the insured; equally or to the survivor(s).
- **Unequal distribution**: For unequal distributions, use fractions or percentages (%) versus dollar amounts.
  - For example, if you are covered for $50,000, and you want $30,000 paid to your wife and $20,000 paid to your son, it could read: "60% to Mary E. Doe (d.o.b. 3/20/70), wife, if living, otherwise to said son; and 40% to James F. Doe (d.o.b. 5/18/94), son, if living, otherwise to said wife.
- **Primary and contingent beneficiaries**: Mary E. Doe (d.o.b. 3/20/70), wife, if living; otherwise equally to the insured's then living children.
- **Trustee beneficiary**: The ABC Trust Company, Town, State; as trustee underwritten trust agreement dated MM/DD/YYYY.

Questions?

If you have any questions regarding available benefits or how to file your claim, or if you would like to appeal a determination, please contact our **Customer Care Team** at:

- workplaceclaims@wellfleetinsurance.com
- 1-855-664-5838, 8:30 a.m. - 5:00 p.m. EST

CERTIFICATE HOLDER/CLAIMANT INFORMATION

Certificate number:_____ Group name: _____

Certificate holder: First Name: _____ MI: _____ Last Name: _____

Employer: _____

THIS BENEFICIARY DESIGNATION CANCELS AND SUPERSEDES ALL PREVIOUS REVOCABLE ONES.

I request that the following change(s) be made under the policy and certificate numbers noted above.

Change of insured's name (if applicable)

From: _____

(First, middle, last)

To: _____

Change of beneficiary or Initial beneficiary election

Change to:

_____

(Name(s), date(s) of birth, relationship* and % to be paid)

_____

(Name(s), date(s) of birth, relationship* and % to be paid)

_____

(Name(s), date(s) of birth, relationship* and % to be paid)

*If a trust is named as the beneficiary, the trustee's name and address must be provided in the "Change of beneficiary" section above. If the trustee changes, Wellfleet Insurance must be informed and provided with the updated information.

I understand that if a beneficiary change is shown above, it will take effect when I sign my name below, whether or not the insured is living when the form is received by Wellfleet Insurance. Such a change is without prejudice for payment by Wellfleet Insurance and the company may take action before it receives this form. Also, I reserve the right to change a beneficiary designed above, unless I have indicated that it is "irrevocable". I understand that if two or more beneficiaries are designated, any payment made to them will be in equal shares, unless stated otherwise.

Dated at _____

(Street address, City, State, Zip code)

On _____ By _____

(Month, Day, Year) (Signature of owner)