Change of beneficiary or owner

from **Accendo Insurance Company** part of the CVS Health® family of companies and Aetna affiliate

· P.O. Box 14795 Lexington, KY 40512-4795

Fill this form out and return ***only*** if you wish to change your beneficiary and/or owner designation(s) or information that you have not previously contacted us with your change(s).

Insured's name	Policy number
Current address *city, state, zip*	Phone number

As Owner of the above policy, I hereby request: **A CHANGE OF PRIMARY BENEFICIARY TO:** ***(% Percentages MUST total 100%)***

Primary beneficiary *Full legal name*	Phone number	Social Security Number	Date of birth / /
Mailing address *city, state, zip*		Relationship	% split
Primary beneficiary *Full legal name*	Phone number	Social Security Number	Date of birth / /
Mailing address *city, state, zip*		Relationship	% split
Primary beneficiary *Full legal name*	Phone number	Social Security Number	Date of birth / /
Mailing address *city, state, zip*		Relationship	% split

As Owner of the above policy, I hereby request: **A CHANGE OF CONTINGENT BENEFICIARY TO:** ***(% Percentages MUST total 100%)***

Contingent beneficiary *Full legal name*	Phone number	Social Security Number	Date of birth / /
Mailing address *city, state, zip*		Relationship	% split
Contingent beneficiary *Full legal name*	Phone number	Social Security Number	Date of birth / /
Mailing address *city, state, zip*		Relationship	% split
Contingent beneficiary *Full legal name*	Phone number	Social Security Number	Date of birth / /
Mailing address *city, state, zip*		Relationship	% split

As Owner of the above policy, I hereby request: **A CHANGE OF OWNERSHIP TO:**

CHANGE OWNER TO:	Phone number
Mailing address *city, state, zip*	Relationship

A designation of a change of first or primary beneficiary will revoke all previously named first or primary beneficiaries, and a designation of a change of second or contingent beneficiary will revoke all previously named second or contingent beneficiaries. Any change of beneficiary requested shall not be effective unless recorded by the Company. The effective date of a recorded change shall be the date this request is signed, if signed during the lifetime of the Insured, whether or not the Insured is living when the change is recorded. A change of beneficiary is subject to any payment made or other action taken by the Company before the change is recorded. After recording, a copy of this form will be returned to be attached to the policy.

_____ _____

Signature of Owner or Authorized Agent *for the Owner* ***Date***

_____

Witness to Signature

*** If signed by anyone other than the owner, this request* ***MUST*** *include a copy of your authorized agent documents unless previously submitted to our company as records of this policy.* ***This request will be denied if the form is incomplete or missing any supporting documentation required for approval.***

Mail or fax completed form to:

PO Box 14770
Lexington, KY 40512-4770

Fax:
855-829-4026

Acknowledgement and waiver

Receipt of the above request is acknowledged. Any policy provisions requiring the endorsement of a change of beneficiary are waived with the respect to this change of beneficiary only.

CVS Health®