



Change of Beneficiary and/or Name

Completed form should be given to the Policyholder so that the change can be indicated on the "Insurance Record"
The Policyholder will forward the form to BC Life & Health Insurance Company.

Insured Information

Name of Insured – Last name, First name, M.I.

Group No.	Section No.	Certificate No.
Insured's Street Address		City / State / ZIP code
Name of Employer		
Sugsiary, Affiliate or Member of:		

Change of Beneficiary

I hereby revoke any current designations and change my beneficiary(s) to:

If more than one beneficiary is designated, interest will be equal unless otherwise indicated.

Change Name of Insured

Last Name	First Name	M.I.
Last Name	First Name	M.I.
Signature of Owner	Phone No.	Date

SEND THIS COMPLETED FORM TO:
 BC Life & Health Insurance Company
 Small Group Services
 P.O. Box 9062
 Oxnard CA, 93031-9062

IF YOU HAVE ANY QUESTIONS, PLEASE CALL OUR TOLL FREE NUMBER:
(800) 551-7564
 Monday – Friday, 8:30 am to 4:30 pm

DISTRIBUTION: ORIGINAL – Return to BC Life & Health Insurance Company COPY – Retain and attach to certificate