



FAMILY MATTERS. NO MATTER WHAT.®

POLICY INFO CHANGE FORM

Thank you for being a valued Boston Mutual Life Insurance customer. **Please complete any section below that applies and return the completed form to the address or fax number at the bottom of this page.** If you have any questions please call our Client Services Department at (877) 624-2249.

As owner of the policy(ies) noted below, I authorize you to make the following changes as indicated:

POLICY #: _____ INSURED NAME: _____

NAME CHANGE Insured Payor Beneficiary Owner
(Please do not use this form to designate a new beneficiary or owner.)

FORMER NAME: _____ NEW NAME: _____

Reason for Change: _____
(Please Note: If other than for a spelling error or for Marriage or Divorce – you must provide proof of the change.)

ADDRESS CHANGE Insured Payor Beneficiary Owner Employer (List Bill)

NEW RESIDENTIAL ADDRESS: _____

NEW MAILING ADDRESS: _____

SOCIAL SECURITY NUMBER CORRECTION:
(For policyowner only. Social Security Number for individuals, Corporate Tax I.D. Number for companies.)

OWNER'S NAME: _____ CORRECTED SSN: _____

Reason for Change: _____ *(Requires proof of the corrected SSN)*

LOST POLICY CERTIFICATE REQUEST

DUPLICATE POLICY REQUEST (THERE IS A \$ 10.00 CHARGE FOR A DUPLICATE POLICY WHICH MUST ACCOMPANY YOUR REQUEST)

I have made a persistent search for this policy, but have no knowledge of its whereabouts.

My policy is unobtainable at this time, but I agree to send it to Boston Mutual if and when it is located

Please complete the section below, incomplete and/or missing information may delay this request:

DATE _____

OWNER NAME _____

AGENT/WITNESS SIGNATURE _____
(A witness signature is not required but is strongly recommended)

OWNER SIGNATURE _____

(____) _____ - _____
TELEPHONE NUMBER

____ XXX / XX / _____
OWNER SOCIAL SECURITY NUMBER

RESIDENTIAL ADDRESS _____