



CLIENT SERVICES  
DEPARTMENT

Dear Policyholder:

**Please complete the appropriate section and mail or fax the completed form to the address or fax number noted above.** 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 CHANGE**                      Insured      Payor      Beneficiary      Owner

(Do not use this form to designate a new beneficiary or owner.)

FORMER NAME: \_\_\_\_\_ NEW NAME: \_\_\_\_\_

Reason for Change: \_\_\_\_\_

**ADDRESS CHANGE**                      Insured      Payor      Beneficiary      Owner      Employer (List Bill)

NEW ADDRESS: \_\_\_\_\_

\_\_\_\_\_

**TAX IDENTIFICATION NUMBER (TIN) CORRECTION**

(For policyowner only. Social Security Number for individuals, Corporate Tax I.D. Number for companies.)

OWNER'S NAME: \_\_\_\_\_ CORRECTED TIN: \_\_\_\_\_

Reason for Change: \_\_\_\_\_

**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 this section with all appropriate signatures and information. Missing data may delay processing.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
OWNER SIGNATURE

\_\_\_\_\_  
AGENT/WITNESS SIGNATURE

\_\_\_\_\_  
OWNER SOCIAL SECURITY NUMBER

\_\_\_\_\_  
OWNER ADDRESS

\_\_\_\_\_  
(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
TELEPHONE NUMBER