

# APPLICATION FOR CHANGE OF BENEFICIARY

**AMERICAN POSTAL WORKERS  
ACCIDENT BENEFIT ASSOCIATION**  
P.O. Box 120  
Rochester, NH 03866  
(603) 330-0282



## YOUR NON-PROFIT BENEFIT PLAN

I hereby apply for a change of beneficiary(s), and desire to have the accidental death benefits provided in the Certificate made payable in case of my accidental death under its provisions to:

*(Please Print)*

Full Name	Date of Birth	Relationship	Benefit Percentage
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Full Name	Date of Birth	Relationship	Benefit Percentage
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In the event of his/her death then to:

Full Name	Date of Birth	Relationship	Benefit Percentage
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Full Name	Date of Birth	Relationship	Benefit Percentage
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I understand that this designation replaces any and all other previous beneficiary(s) designation. I also understand that if no Benefit Percentage is listed then benefits will be shared equally.

\_\_\_\_\_  
Member *(please print)*

\_\_\_\_\_  
Signature

*(Must be witnessed by someone other than a named beneficiary)*

I certify that the above applicant is personally known to me and has signed this Application in my presence.

Witnessed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Witness *(please print)*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness Address

\_\_\_\_\_  
Witness City, State, Zip