

APPLICATION FOR CHANGE OF BENEFICIARY
American Postal Workers Accident Benefit Association
National Director, PO Box 120, Rochester, NH 03866

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

Full Name	Relationship	Date of Birth	Benefit Percentage
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Full Name	Relationship	Date of Birth	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

Member's Social Security Number

(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