

# National Peace Officers & Firefighters Benefit Association (NPFBA) Change of Beneficiary (COB)

Name \_\_\_\_\_  
Last First M. I.

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_      Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (    ) \_\_\_\_\_ - \_\_\_\_\_      EMAIL \_\_\_\_\_

***Beneficiary***

Name	
Relationship	

***Contingent Beneficiary***

Name	
Relationship	

\_\_\_\_\_  
 Signature \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

## Protection Against Unintended Lapse

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid.

I designate the following person(s) to receive notice prior to cancellation of my policy for nonpayment of premium:

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

I elect not to designate any person to receive such notice.

**NOTE:** A signature is required for this form to take effect. Contact the plan administrator toll free at 1-877-582-0003 with questions, or visit [www.npfba.org](http://www.npfba.org)

Please do not write in this space <b>Office use only</b>	Date Received: _____
	Address Updated: _____
	Files Updated: _____