Please print and mail to: NPFBA, PO Box 31, Martell, CA 95654

# 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** _____

## *Primary Beneficiary (Please do not list minor children as Beneficiary)*

| | |
|---|---|
| **Name** | |
| **Relationship** | |
| **Address** | |
| **Phone** | |

## *Contingent Beneficiary (Please do not list minor children as Beneficiary)*

| | |
|---|---|
| **Name** | |
| **Relationship** | |
| **Address** | |
| **Phone** | |

_____ ___/___/_____
**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**

| | |
|---|---|
| **Please do not write in this space Office use only** | **Date Received:** _____<br>**Address Updated:** _____<br>**Files Updated:** _____ |