

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	

Contingent Beneficiary (Please do not list minor children as 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

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