



□ Northeast Regional Office  
P.O. Box 26050  
Lehigh Valley, PA 18002-6050

□ Midwest Regional Office  
P.O. Box 8012  
Appleton, WI 54912-8012

□ Bridgewater Office  
P.O. Box 425  
E. Bridgewater, MA 02333-0425

□ Western Regional Office  
P.O. Box 2454  
Spokane, WA 99210-2454

## Request for Change of Beneficiary and/or Name

**PLEASE TYPE or PRINT CLEARLY.** (The entire form, properly completed, signed and dated by the Insured, must be submitted or the changes cannot be processed.)

PLANHOLDER  
NAME

STREET  
ADDRESS

CITY, STATE  
AND ZIP

**GROUP PLAN NUMBER**

EMPLOYEE NAME (LAST, FIRST, M.)

CERT.#

SOCIAL SECURITY #

EMPLOYEE HOME ADDRESS (STREET, CITY, STATE, ZIP)

**The Guardian Life Insurance Company of America is hereby requested to make the following changes:**  
**(PLEASE COMPLETE THE APPROPRIATE SECTIONS ONLY.)**

**CHANGE IN BENEFICIARY:** (Complete only to change the Beneficiary Designation); Include full proper name, relationship and social security number of proposed beneficiary(s) – i.e. Mary A. Doe, and relationship – i.e. husband, wife, friend, son, daughter.

If more than one Beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan.

SIGNATURE OF INSURED

SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY)

DATE

**ALL SIGNATURES MUST BE IN INK**

**CHANGE IN BENEFICIARY'S NAME** (Complete only if the name has been legally changed.)

FROM (WAS)

TO (NOW IS)

SOCIAL SECURITY #

DATE

**CHANGE IN INSURED'S NAME** (Complete only if the name has been legally changed.)

FROM (WAS)

TO (NOW IS)

SOCIAL SECURITY #

DATE

SIGNATURE OF INSURED

DATE

**ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM**

**THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY.**

This is to certify that the following changes have been recorded in connection with the insurance evidenced by the above certificate.

The BENEFICIARY has been changed

The NAME of the BENEFICIARY has been changed

Recorded by \_\_\_\_\_ Date \_\_\_\_\_

GG-17 (2/05)

**ATTACH A COPY TO THE ENROLLMENT FORM AND A COPY TO THE GROUP INSURANCE CERTIFICATE**