

J. J. STANIS and COMPANY, INC.

100 Jericho Quadrangle • Suite 101
Jericho • New York 11753

GROUP INSURANCE REQUEST FOR

CHANGE OF BENEFICIARY
(Please Print All Information)

Phone: (516) 465-3900

Fax: (516) 465-3920

POLICY HOLDER: _____ OCCUPATION: _____
 INSURED NAME: (LAST) _____ (FIRST) _____
 HOME ADDRESS: _____ CITY _____ STATE _____ ZIP _____
 DATE OF BIRTH: _____ SEX: MALE FEMALE
 SOCIAL SECURITY NUMBER: _____ DATE OF EMPLOYMENT: _____
 ANNUAL SALARY: _____ HOURS WORKED WEEKLY: _____
 MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED SEPARATED

PRIMARY BENEFICIARY: _____ RELATIONSHIP: _____

CONTINGENT BENEFICIARY: _____ RELATIONSHIP: _____

If more than one beneficiary is named, the death benefit, unless otherwise provided herein, will be paid in equal shares to the designated beneficiaries who survive the employee. If no such beneficiary survives, payment will be made in accordance with the terms of the policy.

DATE: _____
Witness by someone other than named Beneficiary. _____ SIGNATURE OF INSURED

WITNESS SIGNATURE

Address of Witness _____