



**BENEFICIARY CHANGE REQUEST  
 FOR BLUE SHIELD OF CALIFORNIA LIFE & HEALTH INSURANCE COMPANY (BLUE SHIELD LIFE)**

**IMPORTANT:** PLEASE PRINT ALL SECTIONS IN BLACK INK.

GROUP NAME	
POLICY NUMBER	
INSURED'S NAME	SOCIAL SECURITY NUMBER

Blue Shield Life will pay the proceeds to the primary beneficiary. If more than one person is named as primary beneficiary, the proceeds will be distributed equally to those who survive the insured, unless otherwise specified in the % column.

**SECTION 1 – PRIMARY LIFE INSURANCE BENEFICIARIES**

LAST NAME	FIRST NAME	M.I.	%	RELATIONSHIP TO EMPL./MEM.	BIRTH DATE
SOCIAL SECURITY NUMBER	MAILING ADDRESS (NUMBER, STREET, APARTMENT)		CITY	STATE	ZIP
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Proceeds will be paid to a contingent beneficiary only if no primary beneficiary survives the Insured.

**SECTION 2 – CONTINGENT LIFE INSURANCE BENEFICIARIES**

LAST NAME	FIRST NAME	M.I.	%	RELATIONSHIP TO EMPL./MEM.	BIRTH DATE
SOCIAL SECURITY NUMBER	MAILING ADDRESS (NUMBER, STREET, APARTMENT)		CITY	STATE	ZIP
SOCIAL SECURITY NUMBER	MAILING ADDRESS (NUMBER, STREET, APARTMENT)		CITY	STATE	ZIP

\_\_\_\_\_  
 DATE

\_\_\_\_\_  
 INSURED'S SIGNATURE

\_\_\_\_\_  
 WITNESS