TEXAS MEDICAL ASSOCIATION INSURANCE TRUST
BENEFICIARY CHANGE FORM

Name of insured: _____ _____ _____
Last First MI

Certificate #: _____ Social Security #: _____

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BENEFICIARY DESIGNATION

Please list the product(s) for which the designation applies: (Example: Member Term Life, Employer Term Life, Personal Accident, Employee Life Insurance)

Product: _____

Beneficiary: _____ _____
Full Name Social Security Number

_____ _____
Relationship to Insured Beneficiaries Date of Birth

_____ _____
Beneficiaries Address Beneficiaries Phone Number

*If the beneficiary if a Trust we need the Trust Tax ID Number: _____

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_____ _____
Insured's Signature **Date**

_____ _____
Witness **Date**