GUARDIAN®

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

□ Midwest Regional Office
P.O. Box 8012
Appleton, WI 54913-8012

□ Norwell Regional Office
P.O. Box 9121
Norwell, MA 02061-9121

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

Form No. GG-17

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 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 THE 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 _____

(11/98)

ATTACH TOP COPY TO THE ENROLLMENT FORM, SECOND COPY TO THE GROUP INSURANCE CERTIFICATE