

# NATIONAL CATHOLIC SOCIETY OF FORESTERS

320 S. School Street – Mount Prospect, IL 60056-3334 – 1.800.344.6273 – www.ncsf.com

Date:

Name:

Address:

City, State, ZIP:

**RE: Change of Beneficiary  
Certificate                      Court                      Roster**

In response to your recent request, we are enclosing a change of beneficiary form for the above named certificate.

1. Please print clearly using black or blue ink
2. Check the Primary or Contingent box for your beneficiary(ies)
3. Sign and date page 3 of the form
4. **Your signature must be witnessed by a Notary Public**

**IN SECTION 3: We are *not permitted* to name a specific funeral home or mortuary as beneficiary due to Illinois Law and National Catholic Society of Foresters' bylaws.**

If you wish to use a designation to cover funeral expenses, payment will be made to the funeral home or person who pays the funeral bill in accordance with the information we received from the appropriate funeral home. Any balance remaining after we satisfy the funeral bill will be paid to the named beneficiary.

If we do not hear from you within 30 days we will assume you do not want to make any changes. If you have any questions or need any assistance, contact us.

Fraternally,

Dan McHale  
Benefit Transaction Representative  
800-344-6273 ext. 200

## EXAMPLES OF ACCEPTABLE ILLUSTRATIVE BENEFICIARY DESIGNATIONS

The use of "And / Or" is not an acceptable term. The use of "Or" is not an acceptable term.

- |   |   |
|---|---|
| 1) <b>Insured's Estate:</b> "To the Executor / Administrator of the insured's estate."  | 5) <b>Trust:</b> Name of trust and date of trust. If the trust is not in effect as of the insured's date of death, payment will be made to the estate of the insured. |
| 2) <b>Primary Beneficiary (one only):</b> "Mary Smith - Wife."<br>If the Beneficiary is not related to the insured, "John Smith - Friend."  | 6) <b>Last Will in Testament Trust:</b> Payment will be made to the trustee of the trust established as of the insured's date of death.                               |
| 3) <b>Two Beneficiaries (two or more equally):</b> "John Smith and Mary Smith- Parents." Payment to be made equally to beneficiary or beneficiaries who survive the insured.                  | 7) <b>Children and Grandchildren:</b> "To the living descendants of the insured per stirpes."   |
| 4) <b>Organization:</b> "To ( <i>Corporate Name</i> ) ( <i>Principle Office Address</i> ) to be used for (indicate what purpose)." Contact Organization to obtain Corporate Name and Address. |   |

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## CHANGE OF BENEFICIARY

Insured \_\_\_\_\_ Owner - if other than Insured \_\_\_\_\_

Certificate \_\_\_\_\_ Court \_\_\_\_\_ Roster \_\_\_\_\_

After this change has been acknowledged in the Home Office, the effective date of change will be the owner signature date. All prior beneficiary designations are revoked. The Society and Owner waive all requirements that a change of beneficiary be endorsed on the certificate.

### 1) BENEFICIARY(IES): Use this space to name your Primary and Contingent Beneficiaries.

Primary  Contingent

_____ <b>FIRST NAME</b>	_____ <b>LAST NAME</b>	_____ <b>RELATIONSHIP</b>	_____ <b>PERCENTAGE</b> %
_____ ADDRESS / APT. NO.	_____ CITY	_____ STATE	_____ ZIP
_____ PRIMARY TELEPHONE NO.	_____ ALTERNATE PHONE NO.	_____ E-MAIL ADDRESS	
_____ SSN / TIN	_____ DOB MM/DD/YYYY	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	

Primary  Contingent

_____ <b>FIRST NAME</b>	_____ <b>LAST NAME</b>	_____ <b>RELATIONSHIP</b>	_____ <b>PERCENTAGE</b> %
_____ ADDRESS / APT. NO.	_____ CITY	_____ STATE	_____ ZIP
_____ PRIMARY TELEPHONE NO.	_____ ALTERNATE PHONE NO.	_____ E-MAIL ADDRESS	
_____ SSN / TIN	_____ DOB MM/DD/YYYY	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	

Primary  Contingent

_____ <b>FIRST NAME</b>	_____ <b>LAST NAME</b>	_____ <b>RELATIONSHIP</b>	_____ <b>PERCENTAGE</b> %
_____ ADDRESS / APT. NO.	_____ CITY	_____ STATE	_____ ZIP
_____ PRIMARY TELEPHONE NO.	_____ ALTERNATE PHONE NO.	_____ E-MAIL ADDRESS	
_____ SSN / TIN	_____ DOB MM/DD/YYYY	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	

Additional Beneficiaries are Attached

**2) IF NAMING A TRUST**

(PLEASE CHECK ONLY ONE)  Primary  Contingent

Trust Agreement Name \_\_\_\_\_ Trust Agreement Date \_\_\_\_\_

Please Note: If the Trust is terminated, payment will be made to the Executor or Administrator of my estate.

**3) IF NAMING A FUNERAL EXPENSE**

We will first satisfy unpaid funeral expenses in accordance with state limitations. Any remainder shall be payable to the said beneficiary and/or beneficiaries.

To qualify for government assistance this designation must be irrevocable, meaning it cannot be changed. The Primary Beneficiary must be named as "Funeral Expenses, Irrevocably" and the Contingent Beneficiary must be "Insured's Estate".

\_\_\_\_\_  
PRIMARY BENEFICIARY

\_\_\_\_\_  
CONTINGENT BENEFICIARY

\_\_\_\_\_  
RELATIONSHIP

\_\_\_\_\_  
PERCENTAGE %

\_\_\_\_\_  
ADDRESS / APT. NO. CITY STATE ZIP

\_\_\_\_\_  
PRIMARY TELEPHONE NO. ALTERNATE PHONE NO. E-MAIL ADDRESS

\_\_\_\_\_  
SSN / TIN DOB MM/DD/YYYY Sex:  M  F

Signature of Owner \_\_\_\_\_ Date \_\_\_\_\_

Owner's Social Security Number \_\_\_\_\_

Subscribed and sworn to before me  
on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

**FOR HOME OFFICE USE ONLY**

\_\_\_\_\_  
NOTARY PUBLIC

My commission expires \_\_\_\_\_

Acknowledgement is hereby made of the receipt and acceptance for filing and recording of the original of the foregoing change of beneficiary

\_\_\_\_\_  
National Secretary or Authorized Signature Date