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

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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 ☐ Per Stirpes *(If not checked, designation will be Per Capita)*

FIRST NAME	**LAST NAME**	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

☐ Primary ☐ Contingent ☐ Per Stirpes *(If not checked, designation will be Per Capita)*

FIRST NAME	**LAST NAME**	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

☐ Primary ☐ Contingent ☐ Per Stirpes *(If not checked, designation will be Per Capita)*

FIRST NAME	**LAST NAME**	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

☐ **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

_____ _____ Sex: ☐ M ☐ F
SSN / TIN DOB MM/DD/YYYY

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