ATLANTIC AMERICAN
Employee Benefits

4370 Peachtree Road, NE, Atlanta, Georgia 30319
aaemployeebenefits.com | Tel: (866) 458-7500 | Fax: (404) 926-4033

CHANGE FORM

PLEASE PRINT & COMPLETE ONLY THE APPROPRIATE ITEMS

Policy Number	Email
Insured's Name	**Social Security Number**
Owner's Name	**Social Security Number**

❑ 1. **NAME CHANGE:** Change name of ❑ Insured ❑ Owner ❑ Payor ❑ Beneficiary

Print Former Name: _____ Signature: _____
(not required for Beneficiary)

Print New Name:_____ Signature: _____
(not required for Beneficiary)

Reason for Change: _____ Effective Date:_____
(If other than correction, attach a copy of legal evidence)

Address:_____ Phone #_____

❑ 2. **OWNERSHIP CHANGE:** Transfer ownership of the policy to:

Name: _____ Social Security #_____

Address: _____ Phone # _____

Signature of New Owner: _____ Relationship to Insured: _____

❑ 3. **CHANGE OF BENEFICIARY:**

PRIMARY BENEFICIARY (IES) Equally, unless otherwise provided in percentages

Name: _____ %_____ Social Security # _____

Address: _____

Relationship: _____ Phone # _____ Birth Date_____

Name: _____ %_____ Social Security # _____

Address: _____

Relationship: _____ Phone # _____ Birth Date_____

CONTINGENT BENEFICIARY (IES) If no Primary Beneficiary survives the Insured, then,

Name: _____ %_____ Social Security # _____

Address: _____

Relationship: _____ Phone # _____ Birth Date_____

Name: _____ %_____ Social Security # _____

Address: _____

Relationship: _____ Phone # _____ Birth Date_____

❑ 4. **CERTIFICATE OF INSURANCE OR DUPLICATE POLICY:** I certify I have been unable to find the above-described policy and that it is not assigned or pledged. I request the issuance of a certificate of insurance, or duplicate policy, if available.

SIGNATURES: I/We agree that my/our signature(s) below shall apply to each request which has been checked.

Policy Owner	Date	Assignee Officers Signature	Date
Witness	Date	Assignee Title & Company	