TIP Friendly Society
Beneficiary Change Form

This application form exists solely for existing members to make the necessary changes as it relates to their beneficiaries. Please fill out application form completely and accurately. Write not applicable (N/A) in areas that do not apply. Minors listed as beneficiaries will only receive proceeds upon reaching the age of majority (18). This change will be effected the day that the relevant document is completed and signed *by the Insured.*

MEMBER INFORMATION	
Member No:	Date:
Miss Ms. Mr. Mrs.	Name:
Date of Birth (D/M/Y):	Phone:
Current Address:	

EMPLOYMENT INFORMATION	
Place of Work:	School No.:
Work Address:	
	Phone:

BENEFICIARIES TO BE ADDED

Name (Using "BLOCKED LETTERS")	"P", "S", or "F"	Date of Birth	Relationship	Contact Number
		(D/M/Y):		
		(D/M/Y):		
		(D/M/Y):		
		(D/M/Y):		
		(D/M/Y):		

PLEASE STATE BRIEFLY YOUR REASON(S) FOR THIS ADDITION:

BENEFICIARIES TO BE DELETED

Name (Using "BLOCKED LETTERS")	"P", "S", or "F"	Date of Birth	Relationship	Contact Number
		(D/M/Y):		
		(D/M/Y):		
		(D/M/Y):		
		(D/M/Y):		
		(D/M/Y):		

PLEASE STATE BRIEFLY YOUR REASON(S) FOR THIS DELETION:

GENERAL INFORMATION

Beneficiaries may be placed in categories of:

a) **Primary (P).** The primary beneficiary is the person that is entitled to receive proceeds in the event of death of the Insured.
b) **Secondary (S).** The secondary beneficiary may be listed as a precaution. This category of beneficiary will stand to benefits from proceeds in the event of the death of the primary beneficiary.
c) **Final (F).** The final beneficiary will stand to gain proceeds in the eventuality of death of both the primary and secondary beneficiary.

If there is more than one beneficiary, all can be categorised as being primary. This will ensure that the proceeds are shared equally between/among all persons listed in this category.

This form signifies the Insured's desires/intentions, and can only be changed or adjusted by the Insured. Any changes in relation to beneficiaries that are made on this form shall replace all other existing designations.

DISCLAIMER & SIGNATURE

I certify that the information given in this application is true and complete to the best of my knowledge and belief.

Insured's Signature _____ Date _____

Representative's Name (Please Print) _____ Date _____

Representative's Signature _____