J. J. STANIS and COMPANY, INC.
377 Oak Street · Suite 406
Garden City · New York 11530

GROUP INSURANCE REQUEST FOR CHANGE OF BENEFICIARY
(Please Print All Information)

Phone: (516) 465-3900
Fax: (516) 465-3920

POLICY HOLDER:_____ OCCUPATION:_____
INSURED NAME: (LAST)_____ (FIRST)_____
HOME ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____
DATE OF BIRTH:_____ SEX: ☐ MALE ☐ FEMALE
SOCIAL SECURITY NUMBER:_____ DATE OF EMPLOYMENT:_____
ANNUAL SALARY:_____ HOURS WORKED WEEKLY:_____
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED

PRIMARY BENEFICIARY: _____
_____ RELATIONSHIP:_____
_____

CONTINGENT BENEFICIARY: _____ RELATIONSHIP:_____
_____
_____

If more than one beneficiary is named, the death benefit, unless otherwise provided herein, will be paid in equal shares to the designated beneficiaries who survive the employee. If no such beneficiary survives, payment will be made in accordance with the terms of the policy

DATE: _____ _____
Witness by someone other than named Beneficiary SIGNATURE OF INSURED

_____
WITNESS SIGNATURE

_____
Address of Witness