Standard Insurance Company

Change Form

Mark all boxes and complete all sections that apply. Return completed form to your Employee Benefits Department.

APPLICANT

Your Name (Last, First, Middle)		Group Name	Group Number(s)	APS Employee No.
		Albuquerque Public Schools	**645746**	
Your Address		City	State	ZIP
Your Soc. Sec. No.	Date of Birth	☐ Male ☐ Female	Job Title/Occupation	

CHANGE

Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.

☐ Beneficiary Change ☐ Name Change

Date of add/delete _____ Former name _____

LIFE

Check with your Employee Benefits Department about coverage

☒ Retiree Life Insurance

Retiree Albuquerque Public Schools

BENEFICIARY

This designation applies to ~~Basic~~ Life Insurance available through ~~your Employer~~. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.

Primary - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Contingent - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

SIGNATURE

I wish to make the choices indicated on this form.

Member/Employee Signature Required	Date (Mo/Day/Yr)