COMBINED INSURANCE

COMBINED ASSURANCES

REQUEST FOR NAME CHANGE

Name of owner: _____

Address: _____

_____

IMPORTANT: Please enclose a copy of any legally accepted verification of this change (for example: birth certificate, driver's license, passport, enlistment or discharge papers, or marriage certificate)

Complete and return this form to our Administrator at:

Combined Insurance/Combined Assurances
P.O. Box 3720, MIP, Markham (Ontario)
L3R 0X5

Fax # 905 305-8600

NOTE: The Beneficiary Designation of the policy is NOT affected by this form. Change of Beneficiary forms are available from the Company upon request.

Policy number	Name of insured person (first, middle initial, last)		
Change the name of the:	☐ Owner	☐ Contingent Owner	☐ Insured person
	☐ Dependent	☐ Primary beneficiary	☐ Secondary beneficiary
From			
To			
Reason of change	☐ Marriage	☐ Divorce	
	☐ Adoption	☐ Other _____	
Date of change (DD/MM/YYYY)			

Dated at _____ this _____ day of _____ 20 _____

Signature of insured person X
Signature of the owner (if other than insured person) X

Combined Insurance Company of America / Compagnie d'assurance Combined d'Amérique
Canadian Head Office / Siège social canadien : P.O. Box 3720, MIP, Markham (Ontario) L3R 0X5
Telephone / Téléphone : 1 888 234-4466
www.combined.ca

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