California Association of Professional Firefighters (CAPF) Change of Beneficiary (COB)

LAST NAME	FIRST NAME	M.I.	BIRTHDATE	SOCIAL SECURITY NO.

MAILING ADDRESS	NAME OF EMPLOYER

CITY	STATE	ZIP CODE	PHONE

CURRENT TITLE	E-MAIL

Please change my beneficiary to:

Beneficiary (Name) _____ Relationship _____
(Do not list minors.)

Contingent Beneficiary (Name) _____ Relationship _____
(Do not list minors.)

Your Signature _____ Date _____

Please do not write in this space. Office use only.

Date Received: _____

Address Updated: _____

Files Updated: _____

Note: A signature is required for this form to take effect. Contact Plan Administrator at 1-800-832-7333 with questions, or visit www.capf.org.

CAPF-WEB-COB Rev. 08/05

Beneficiary change will not take effect until card has been received and accepted by Plan Administrator.

Please print, sign and mail this card to:

CAPF

LTD Beneficiary Change

PO Box 31

Martell, CA 95654