APPLICATION TO DESIGNATE OR CHANGE BENEFICIARY

Please complete this form and return to:

American Postal Workers Accident Benefit Association - PO Box 120, Rochester, NH 03866

I hereby request to have accidental death benefits provided in the Certificate made payable in case of my accidental death under its provisions to:

(Please Print) List as many or as few as you require

Full Name	Relationship	Date of Birth	Benefit Percentage
Full Name	Relationship	Date of Birth	Benefit Percentage
Full Name	Relationship	Date of Birth	Benefit Percentage
Full Name	Relationship	Date of Birth	Benefit Percentage

In the event of prior death then to:

Full Name	Relationship	Date of Birth	Benefit Percentage
Full Name	Relationship	Date of Birth	Benefit Percentage
Full Name	Relationship	Date of Birth	Benefit Percentage
Full Name	Relationship	Date of Birth	Benefit Percentage

I understand by signing this designation, all other previous beneficiary(s), if any, will be replaced. I also understand that if no Benefit percentage is listed, benefits will be shared equally.

Member Name (please print) _____ Signature _____

Member's SS# / EID# _____