

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 _____

Contingent Beneficiary (Name) _____ Relationship _____

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

After signing this card please mail to:

CAPF
 LTD Beneficiary Change
 PO Box 31
 Martell, CA 95654