## Change Request

## ... MassMutual

Use this form to change the name and/or address and change the mode of premium payment. For additional information, contact your personal financial representative or the applicable MassMutual Service Center as noted in section E – Submission & Contact Information.

A Policy Information ::::::::::::::::::::::::::::::::::::
1. Policy number(s):
2. Insured full legal name (First, MI, Last, Suffix):
B Owner Information::::::::::::::::::::::::::::::::::::
1. Full legal name:
If the Owner's name and/or address has changed, complete section C – Change Request Information below.
2. Taxpayer Identification Number (SSN/ITIN/EIN):
3. Phone number:
Receive a text message regarding the status of this request. By checking this box, you agree to receive text messages regarding the request to your mobile phone. These messages may be sent through an automated system. Standard message and data rates may app to any SMS or MMS you send or receive as part of this program. You may reply to a text with STOP to cancel notifications at any time.
4. Email address:
Receive an email regarding the status of this request. By checking this box, you agree to receive emails regarding this request to you email address. These emails may be sent through an automated system.
5. Is this Policy collaterally assigned?
If Yes, complete assignee information below. If No, skip to section C – Change Request Information.
☐ Individual(s) → Print individual's full legal name (First, MI, Last, Suffix):
☐ Corporate Entity → Print Entity name:
☐ Trust → Print full name & date of Trust (mm/dd/yyyy):
Change Request Information ::::::::::::::::::::::::::::::::::::
For a name change, complete questions 1-4. For an address change, complete questions 5-8. For a change of premium billing frequency, complete question 9.
Change of Name
Documentation of the name change must be submitted with this request. This form does <u>not</u> change the owner or beneficiary designation. If the name change is a life event, your beneficiary may need to be changed.
1. Role (Select one):   Beneficiary  Insured  Owner  Payee  Payer
2. Current full legal name (First, MI, Last, Suffix):
3. New full legal name (First, MI, Last, Suffix):
4. Reason (Select one):
Court order (Attach court order)
Correction (Attach copy of government-issued identification)
☐ Marriage (Attach marriage certificate)
☐ Divorce (Attach divorce decree)
Other (Specify):

Change of Address	i		
5. Full legal name (Fir	rst, MI, Last, Suffix):		
6. Taxpayer Identificat	tion Number (SSN/ITIN/EIN):		
7. Mailing address (PC	O Box or Street, Apt. or Suite #, City & S	ate or Country, ZIP/Postal Code):	
8. If permitted by the te	erms of the policy, send future premium no	tices to person/address listed in questions 5-7 of this section	n: Yes No
Change Premium P	ayment Frequency		
9. Change premium pa	ayment mode to (Select one):		
☐ Annual ☐ S	Semi-annual	le for Disability Income products)	
Add or Revoke Auto	omatic Premium Loan (APL) or Auton	atic Application of Dividends	
10. Automatic Premium	Loan provision (APL): Add	Revoke	
11. Automatic Application	on of Dividends provision: Add	Revoke	
income to the extent of your tax advisor.	f the gain in the policy. If you are under a	wment Contract (MEC), any automatic premium loan will age 59½, any taxable premium loan may be subject to a 10 <sup>t</sup>	% tax penalty. Consul
<b>D</b> Agreements	& Signatures ::::::::::		
By signing below, the Ow certifies that s/he is of le	ner acknowledges that s/he has read thi	form and understands the implications of their request. Ead or subject to any bankruptcy proceeding, attachment, lie	ach of the undersigned
Faxpayer Identification N	lumber; (2) I am not subject to backup wit	under penalties of perjury that: (1) the number shown in so nholding; (3) I am a U.S. person (including U.S. resident alion In FATCA reporting is correct. Strike out any of these state	en); and (4) the FATCA
	o enter an exemption code. If you have	FATCA does not apply to a U.S. account owned by a U.S. ndicated that you are not a U.S. person, any applicable F	,
The Internal Revenue a required to avoid back		consent to any provision of this document other tha	an the certifications
Signature of Owner	er:		
Printed name: _		Date:	
Title (If applicable	):		Sole Officer*
Printed name of C	Corporation/Partnership/Trust (If application)	ole):	
Signature of Joint	Policy Owner (If applicable):		
Olgitature of John			
		Date:	

\*If the Sole Officer box is selected and the signer is the only officer, a signed letter on company stationery to that effect or the signer's signature with the corporate seal affixed is required.

Policy number(s):  Agreements & Signatures continued • • • • • • • • • • • • • • • • • • •				
Signature of Assignee:  Printed name:  Title (If applicable):  Printed name of Corporation/Partnership/Trust (If applicable):		Date: Sole Officer*		
Signature of Additional Assignee (If app. Printed name:	olicable):	Date:		
, , ,	Title (If applicable):  Printed name of Corporation/Partnership/Trust (If applicable):			
For more information or general questions, pleted this form, return all pages for proces		nassmutual.com. Once you have reviewed and com-		
Phone: 1-800-272-2216  Monday through Friday, 8 a.m. – 8 p.m. Eastern Time	Mail: MassMutual Attention: Life Hub 1295 State Street Springfield, MA 01111-0001	Email: LifeFax@MassMutual.com  Fax: Attention: Life Hub 1-866-329-4527 Retain this original and the fax machine confirmation statement for your files.		
Disability Income				
Phone: 1-800-272-2216 Monday through Friday, 8 a.m. – 8 p.m. Eastern Time	Mail: MassMutual Attention: DI Hub 1295 State Street Springfield, MA 01111-0001	Email: DIFax@Massmutual.com  Fax: Attention: DI Hub 1-413-226-4024 Retain this original and the fax machine confirmation statement for your files.		

Massachusetts Mutual Life Insurance Company (MassMutual), 1295 State Street, Springfield, MA 01111-0001 and its subsidiaries: C.M. Life Insurance Company and MML Bay State Life Insurance Company, 100 Bright Meadow Boulevard, Enfield, Connecticut 06082-1981.