



**CHANGE OF BENEFICIARY DUE TO DEATH OR DISABILITY**

PURCHASER'S NAME: \_\_\_\_\_  
KAPT ACCOUNT NUMBER: \_\_\_\_\_  
ORIGINAL BENEFICIARY NAME: \_\_\_\_\_  
PROJECTED ENROLLMENT YEAR: \_\_\_\_\_  
PLEASE PROVIDE REASON FOR REQUEST \_\_\_\_\_

**THE FOLLOWING INFORMATION IS REQUIRED FOR THE SUBSTITUTE BENEFICIARY:**

SUBSTITUTE BENEFICIARY NAME: \_\_\_\_\_  
RELATIONSHIP TO ORIGINAL BENEFICIARY: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
SOCIAL SECURITY NUMBER: (Required By IRS) \_\_\_\_\_  
BIRTH DATE: (Required By IRS) \_\_\_\_\_

**TO AUTHORIZE THIS CHANGE OF BENEFICIARY, PLEASE SIGN THIS COMPLETED FORM.**

**I CERTIFY THAT THE PERSON WHO IS TO BE SUBSTITUTED IS A RESIDENT OF KENTUCKY OR INTENDS TO ATTEND COLLEGE IN KENTUCKY AND MEETS THE CRITERIA OF A QUALIFIED BENEFICIARY AS SPECIFIED IN THE KAPT MASTER CONTRACT. I ALSO UNDERSTAND THAT MY KAPT CONTRACT MUST BE PAID IN FULL BY JULY 1 OF THE SUBSTITUTE BENEFICIARY'S PROJECTED ENROLLMENT YEAR.**

**PLEASE SEND THIS FORM TO THE FOLLOWING ADDRESS:**

**KAPT, KHEAA, PO Box 798  
Frankfort, KY 40602-0798**

**NOTICE**

**Purchasers knowingly supplying fraudulent documentation as to the residence or intent of the new beneficiary will be denied the opportunity to participate in the plan. In the event a KAPT contract has been revised based upon fraudulent documentation, the contract will be terminated and subject to the assessment of a \$150 termination charge.**