

**POLICY CHANGE FORM  
 (NON-MEDICAL CHANGES)**

**SECTION ONE**

Decrease Specified Amount  
 New Specified Amount \_\_\_\_\_  
 (Not allowed within first policy year)

Deletion of Coverage  
 Please indicate Rider or Benefit to be Deleted  
 \_\_\_\_\_  
 \_\_\_\_\_

Death Benefit Option Change  
 From Type A (increasing amount) to  
 Type B (level amount)

Death Benefit Option Change  
 From Type B (level amount) to  
 Type A (increasing amount)

Change in Frequency of Payment  
 Annual     Semi-Annual     Quarterly

Change in Planned Premium for Universal Life  
 Policies  
 New Amount \_\_\_\_\_ Mode \_\_\_\_\_

Monthly     PAC \*     List Bill

\* PAC Card and Void Check Required  
 Draw date will be policy date unless specific  
 date is shown here \_\_\_\_\_ (1-28 only).

Lost Policy Request (check a box)

Please send a Statement of Insurance Coverage

Other (special request)  
 \_\_\_\_\_  
 \_\_\_\_\_

Please send a complete duplicate policy (\$25 fee).  
 Reason for duplicate policy \_\_\_\_\_

**SECTION TWO**

(Complete with Insured Information)

Insured's Name \_\_\_\_\_

Insured's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_

**SECTION THREE**

(Complete with Owner Information if other than the Insured)

Check here if Insured is the Owner of the policy, otherwise complete Section Three.

Owner's Name \_\_\_\_\_

Owner's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_

Witness \_\_\_\_\_ Signature of Policyowner \_\_\_\_\_

Date \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Agent Name and Number

**ENTITLEMENT FORM**

Policy No. \_\_\_\_\_ Name of Insured \_\_\_\_\_

Instruction: Complete only the appropriate section and sign at the bottom of the form.

**SECTION ONE**

**I. BENEFICIARY CHANGE SECTION (This supercedes all previous designations).**

I elect to change the Beneficiary Designation to the following:

Primary

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Contingent

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

**SECTION TWO**

**II. NAME CHANGE SECTION**

I elect to change the Name of the  Insured  Owner to the following:

Name before change \_\_\_\_\_

Name after change \_\_\_\_\_

Date of change \_\_\_\_\_

Reason for change  Marriage  Divorce  Adoption

Other (Explain) \_\_\_\_\_

**SECTION THREE**

**III. OWNERSHIP CHANGE SECTION**

I elect to change the Policyowner of this contract to the following:

New Owner \_\_\_\_\_ Address of new owner \_\_\_\_\_

Social Security # \_\_\_\_\_

Signature of new owner \_\_\_\_\_

Please Note: Current owner MUST sign below to request this ownership change.

**SECTION FOUR**

**IV. ADDRESS CHANGE SECTION**

Name of Premium Payor \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Witness \_\_\_\_\_ Signature of Policyowner \_\_\_\_\_

Date \_\_\_\_\_ Address \_\_\_\_\_

HO Approval \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_