Request for Service

What type of service are you requesting? Please check only the boxes that apply.

1. General Information

Insured's name as currently listed on the policy: | **Soc. Sec. No: or Date of Birth(mm/dd/yyyy):**

List all policy numbers related to this request (required to process):

Employer Name:

2. Name Change

Previous Name: | Current Name:

Reason: ☐ Correction ☐ Marriage/Divorce ☐ **Other** *Please attach copy of legal evidence.*

3. Address Change

Street | Apt. No. | Telephone (h) (w)

City | State | Zip

4. Request for Beneficiary Designation Form

☐ Please visit us at our website www.coloniallife.com or contact us at 1-800-325-4368 to request a copy of the Beneficiary Change form.

5. Payment Method Change *YOU HAVE A CHOICE OF THREE EASY PAYMENT METHODS. PLEASE SELECT ONE.*

1. ☐ **Please deduct monthly premiums from my banking account.**

Please attach a voided check and circle one range of days you would like your checking account to be drafted.

RANGE: (A) 1st-5th (B) 6th-10th (C) 11th-15th (D) 16th-20th (E) 21st-26th Your draft will occur on one of the dates within the range you have selected. **Signature of checking account owner**: _____

OR

2. ☐ **Please bill me directly**. *Choose one of the following:*

☐ Quarterly *(Submit a payment 3 times your monthly premium.)*

☐ Semi-annually *(Submit a payment 6 times your monthly premium.)*

☐ Annually *(Submit a payment 12 times your monthly premium.)*

OR

3. ☐ **Change to Payroll Deductions**.

Employer Name_____

Account Number _____

Please contact your PA to start payroll deduction.

6. Cancellation, Surrender or Policy Change *YOU MUST ALSO COMPLETE SECTIONS 9, 10, AND 12 ON THE REVERSE SIDE.*

☐ Cancel the policy(s).

☐ Surrender the policy and roll over the cash value to:_____

☐ Cancel the following riders on the policy(s): ☐ Spouse ☐ Dependent ☐ Other_____

☐ Change Two-Parent to Individual ☐ Change Two-Parent to One-Parent ☐ Change One-Parent to Individual

Birthdate_____ Social Security Number _____

Please contact your Colonial representative if you wish to add a family member.

7. Policy Loan *YOU MUST ALSO COMPLETE SECTION 9, 10, AND 12 ON THE REVERSE SIDE.*

PLEASE SELECT ONE OPTION

☐ I am requesting a policy loan for the following amount: $_____

☐ I am requesting a policy loan for the maximum amount available.

By signing on the reverse side, I hereby assign the policy to the insurer as collateral.

Policy loans are available on life policies only. You will receive annual loan interest notices until the loan is fully repaid.

Continued on Reverse Side

Colonial Supplemental Insurance Processing Center

8. Withdrawal / Partial Surrender (Universal Life Policy)

YOU MUST ALSO COMPLETE SECTIONS 9, 10, AND 12.

PLEASE SELECT ONE OPTION

☐ I am requesting a policy withdrawal / partial surrender for the following amount: $_____

☐ I am requesting a policy withdrawal / partial surrender for the maximum amount available.

Only one policy withdrawal / partial surrender is allowed per year for a minimum of $100. There will be a processing fee of $25 or as stated in your policy. If your policy is not a universal life policy and you request a policy withdrawal, we will process the request as a policy loan.

9. Community Property Release

YOU MUST COMPLETE THIS SECTION IF YOU RESIDE IN ONE OF THE FOLLOWING STATES.

Community property states: AZ, CA, HI, ID, LA, NV, NM, TX, WA, WI

Spouse's/former spouse's signature is required in states that have community property laws.

By signing below, I, the spouse/former spouse, agree to the cancellation, surrender, change, loan or withdrawal indicated above.

Signature of spouse/former spouse _____ State_____ Date_____
(MM/DD/YYYY)

Check here when no signature is required because: ☐ Policy owner is single (never married) ☐ spouse is deceased

10. Tax Withholding Options

PLEASE READ AND COMPLETE THIS SECTION IF YOU ARE REQUESTING A SURRENDER OR WITHDRAWAL.

Election of a tax withholding option is not available for tax-qualified products. The insurer is required to withhold 20% of any recognized gain for tax-qualified products unless proceeds are rolled directly into an IRA or other qualified retirement plan.

Under certain criteria established by the Treasury Department, a gain may be reportable by the insurer at the time of surrender, partial surrender or withdrawal of this policy, creating a taxable situation. However, any gain is taxable income for the current tax year.

If a gain is reportable, an IRS Form 1099R will be sent to you at the beginning of the next calendar year, reporting the recognized gain, and a copy of Form 1099R will be sent to the IRS. If a gain is not reportable when the surrender, partial surrender or withdrawal is processed, an IRS Form 1099R will not be sent. In addition, if a gain is reportable, the insurer is required to withhold 10% of any recognized gain, unless the policy owner elects not to have the tax withheld. You may be subject to penalties under the estimated tax payment rules if you elect not to have tax withheld and payments of estimated tax and other withholding are not adequate to satisfy tax liability.

Choose one of the following options. If an option is not selected, a withholding will automatically be made.

☐ I DO NOT want to have Federal Income Tax withheld in conjunction with this surrender/partial surrender/withdrawal.

☐ I DO want to have Federal Income Tax withheld from the surrender/partial surrender/withdrawal proceeds.

11. Other Requests or Remarks

_____

_____

_____

12. Signatures Required

YOU MUST FILL OUT THIS SECTION COMPLETELY IN ORDER FOR US TO PROCESS YOUR REQUEST. BE SURE TO LIST A ***SOCIAL SECURITY NUMBER*** *OR* ***DATE OF BIRTH*** *BELOW. FAILURE TO PROVIDE* ***SOCIAL SECURITY NUMBER*** *OR* ***DATE OF BIRTH*** *MAY DELAY PROCESSING.*

I have carefully read this request and agree that it is properly and fully completed. I understand that this request is subject to the provisions and conditions of the policy and that the company may require additional information or requirements. I certify that the policy is not pledged or assigned to any other person or corporation, except where stated in the request, and that no proceedings or bankruptcy or insolvency have been filed or are now pending.

I certify the **Social Security Number** or **Date of Birth** indicated is correct, and I hereby authorize Colonial to execute this request.

Policy owner's signature_____ Daytime telephone _____

Policy owner's Social Security Number or Date of Birth: _____

Policy owner's address_____

_____

Assignee's signature (if any) _____

Date _____
(MM/DD/YYYY)

PLEASE BE SURE TO SIGN AND DATE.

MAIL TO: Colonial Supplemental Insurance Processing Center, P.O. Box 1365, Columbia, SC 29202-1365

Phone: 1-800-325-4368 / To fax requests: 1-800-561-3082

www.coloniallife.com