

Policy Change Request Form

◆ **GENERAL INFORMATION**

(Please Print)

Name of Insured	Phone Number	Policy Number
.....		
Name of Owner	Phone Number	

◆ **CHANGE OF BENEFICIARY INFORMATION** (If additional space is needed, please attach separate sheet)

<u>Classification</u>	Name	Date of Birth	Social Security	Relationship to Insured	Split %*
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent <input type="checkbox"/> Tertiary				
	Address (Number, Street)	City	State	Zip	Phone Number
.....					
<u>Classification</u>	Name	Date of Birth	Social Security	Relationship to Insured	Split %*
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent <input type="checkbox"/> Tertiary				
	Address (Number, Street)	City	State	Zip	Phone Number

*Split percentages within designated beneficiary classification must equal 100%. If none specified, benefit will be split equally by class.
IMPORTANT NOTE: The above beneficiary designation replaces all previous designations made under the above policy.

◆ **CHANGE OF ADDRESS**

<input type="checkbox"/> Owner <input type="checkbox"/> Insured	Address (Number, Street)	City	State	Zip	Phone Number
				
	Effective Date of Change				

◆ **TRANSFER OF OWNERSHIP**

Name of New Owner	Date of Birth	Social Security	Relationship to Insured
.....			
Address (Number, Street)	City	State	Zip
			Phone Number

◆ **CHANGE OF NAME**

<input type="checkbox"/> Owner <input type="checkbox"/> Insured <input type="checkbox"/> Other (please specify)	From	To
	_____	_____
	Reason for change? <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Court Order <input type="checkbox"/> Other (please specify) _____	
	Former Signature _____	New Signature _____
	1. For all name changes other than by marriage or divorce, attach a certified copy of the legal document (such as a court order, adoption papers) . Change cannot be processed without such proof. 2. If name is that of a corporation, submit certified resolution of the board of directors authorizing name change, and copy of document indicating change officially recorded with state of incorporation.	

◆ **CHANGE OF DIVIDEND OPTION**

- 1) Paid by Check 2) Reduce Premium 3) Purchase Paid-Up Additions
 4) Accumulate at Interest 5) Purchase One Year Term 6) Reduce Policy Loan

If changing from 4 to 3, will accumulated dividends be used to purchase paid-up additions? Yes No If "No", accumulations will be left as a secondary dividend option to accumulate at interest.

If you wish to withdraw accumulations, complete Surrender of Dividend section.

◆ **DECREASE AMOUNT OF INSURANCE**

New Amount \$ _____ Effective Date _____
 (Home Office Use Only)

◆ **MODE CHANGE**

Annual Semi-Annual Quarterly Monthly Effective Date _____
 (Home Office Use Only)

◆ **PAID-UP INSURANCE**

Are dividend accumulations or paid-up additions being used to purchase a paid-up policy?

- Yes No

If Yes, Enter Amount \$ _____ Effective Date _____
 (Home Office Use Only)

◆ **POLICY LOAN**

I hereby apply for a loan on my policy in accordance with the policy's loan provision.

Amount \$ _____ New Loan Balance \$ _____
 (Home Office Use Only)

◆ **SURRENDER OF DIVIDEND**

- | | | |
|--|----------------------------|---|
| <input type="checkbox"/> Surrender Accumulations | Having a value of \$ _____ | Dividend Paid to me:
<input type="checkbox"/> Paid to me by check
<input type="checkbox"/> Used to pay premium
<input type="checkbox"/> Used to reduce policy loan
<input type="checkbox"/> Used to pay loan interest |
| <input type="checkbox"/> Surrender Additions | Having a value of \$ _____ | |
| <input type="checkbox"/> Withdraw dividend to pay premium EACH YEAR. | | |

◆ **SURRENDER OF POLICY**

I hereby request surrender of policy Effective Date _____ (Home Office Use Only)

◆ **MISCELLANEOUS (Use this space for other changes and service requests)**

◆ **DISCLOSURE AND SIGNATURES**

I have reviewed the completed information and it correctly reflects my intended changes. I also certify that, under penalty of perjury, the Social Security Number shown below is my correct number. Any change indicated above will become effective on the date this form is signed, provided this form has been properly executed upon receipt. Social Security Number _____

Signature of Owner ** (see below) _____ Date _____
 For a Beneficiary change, the policy owner's signature must be witnessed by a disinterested person for the change to be accepted on all policies if the policy owner currently resides in the state of Massachusetts.

Signature of Witness _____ Date _____

*Signature of Authorized Individual _____ Date _____
 As* New Owner Assignee Irrevocable Beneficiary
 Power of Attorney** Conservator**

** Certified copy of Appointment required