

# REQUEST FOR CHANGE FORM



Administrative Offices: P.O. Box 83043, Lincoln, NE 68501-3043 • 866-863-9753

I request the below listed changes to be applied to the following policies that I own:

Policy #	Insured	Owner

Please place a check mark next to the changes being made.

**REQUEST TO CANCEL COVERAGE**

I \_\_\_\_\_, owner of the above policy(s) would like to cancel the policy which I have marked.

**CHANGE OF BENEFICIARY**

I hereby revoke any previous designation of beneficiaries and request that the life insurance benefit payable at my death be paid in accordance with the designation below. If more than one beneficiary is designated in the same beneficiary class, payment shall be made in equal shares to the designated beneficiaries of the class who survive me.

**Primary Beneficiary**

Name	Relationship	Date of birth	Social Security Number
Address			

Name	Relationship	Date of birth	Social Security Number
Address			

**Contingent Beneficiary**

Name	Relationship	Date of birth	Social Security Number
Address			

**CHANGE OF NAME**

I elect to change the name of the  Insured  Owner  Payor to the following:  
Please provide a legal document for any name change.

Name before change	
Name after change	Date of change

Reason for change  Marriage  Divorce  Adoption  Other: \_\_\_\_\_

**CHANGE OF ADDRESS**

Address change is for:  Insured  Owner  Payor

New Address	New Phone Number
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**OWNERSHIP CHANGE**

I elect to change the owner of this policy to the following individual and understand that all benefits, rights and privileges incident to ownership of this policy will be vested in the new owner. **Please note:** The CURRENT owner MUST sign below to request this ownership change.

New owner	Social Security Number
Address of new owner	
Signature of new owner	Relationship

**CHANGE OF PAYOR**

(This person will receive all bills for coverage)

New Payor
Address of new payor

**REQUEST FOR DUPLICATE / LOST POLICY**

Reason for request:  Cannot locate  Never received  Other: \_\_\_\_\_

**DECREASE IN COVERAGE**

Policy #: \_\_\_\_\_ (If coverage is to be increased, a new application is required.)

Benefit amount from: \$ \_\_\_\_\_ to: \$ \_\_\_\_\_

Decrease coverage for:  Spouse  Child  Other: \_\_\_\_\_

Specific details/instructions: \_\_\_\_\_

**OTHER**

Signature of owner: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of insured: \_\_\_\_\_ Date: \_\_\_\_\_

Owner's mailing address: \_\_\_\_\_

**For company use only**

The change(s) above have been acknowledged, accepted and recorded by the Company.

By: \_\_\_\_\_ Date: \_\_\_\_\_