



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

### REQUEST FOR CHANGE FORM

I request the below listed changes to be applied to the following policies that I own:  
(please place a check mark next to the policies to be affected).

✓	Policy #	Insured	Owner

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

**1. REQUEST TO CANCEL COVERAGE**

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

**2. 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 \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

**Contingent Beneficiary**  
Name \_\_\_\_\_

Address \_\_\_\_\_

**3. 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: \_\_\_\_\_

**Policy#’s**

**4. CHANGE OF ADDRESS**  Insured  Owner  Payor

New Address \_\_\_\_\_

New Phone Number \_\_\_\_\_

[ ] **5. 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.

New Owner \_\_\_\_\_ SSN# \_\_\_\_\_

Address of new Owner \_\_\_\_\_

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

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

[ ] **6. CHANGE OF PAYOR** (This person will receive all bills for coverage)

New Payor \_\_\_\_\_

Address \_\_\_\_\_

[ ] **7. REQUEST FOR DUPLICATE / LOST POLICY**

Reason for request [ ] Cannot locate [ ] Never received [ ] Other \_\_\_\_\_

[ ] **8. 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 \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

[ ] **9. OTHER**

\_\_\_\_\_  
\_\_\_\_\_

**SIGNATURES**

Date \_\_\_\_\_

Signature of Owner \_\_\_\_\_

Signature of Insured \_\_\_\_\_

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

**For Company Use Only**

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

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