



INSURANCE CO.

A Stock Company Domiciled in Indiana
601 N.W. Second Street, P.O. Box 39,
Evansville, IN 47701-0039
1-800-325-2147

REQUEST FOR SERVICE

Complete requested change(s), sign and date below. Mail to above address.

DO NOT SEND POLICY

Policy Number	Insured	Owner (If other than insured)
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1. BENEFICIARY CHANGE

It is hereby requested that the beneficiary under the above numbered policy be changed as follows:

	Please print name and address in full	Relationship to Insured	Social Security Number	Age
Primary Beneficiary	Name:			
	Mailing Address:			
	City, State, Zip:			
Contingent Beneficiary	Name:			
	Mailing Address:			
	City, State, Zip:			

If an estate is named as a Beneficiary, complete a W-9 Request for Taxpayer Identification Number and Certification form and return to Merit Life along with this Request for Services form.

It is understood and agreed that, unless otherwise directed, proceeds will be paid in equal shares to any primary beneficiaries who survive the insured, but if none survives, proceeds will be paid in equal shares to any contingent beneficiaries who survive the insured.

2. NAME CHANGE Insured Owner Payor

From: (Former Name - Please Print)	To: (New Name - Please Print)
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Reason for change (if reason other than correction, marriage or divorce, attach copy of legal evidence.)

3. MAILING ADDRESS CHANGE

From: (Former Address - Please Print)	To: (New Address - Please Print)
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4. MODE OF PAYMENT OF PREMIUM CHANGE

Change to:

Annual Semi-Annual Quarterly Automatic Bank Withdrawal
(Include Authorization for Recurring Automatic Debit Entries Form)

SIGN HERE FOR ABOVE REQUESTS

_____ Date

_____ Signature of Owner

_____ Signature of Assignee (if any)

_____ Signature of Irrevocable Beneficiary (if any)

(FOR HOME OFFICE USE ONLY)

MERIT LIFE INSURANCE CO. HAS RECORDED THE CHANGE REQUESTED AND RETAINED A PHOTOCOPY OF THE REQUEST

DATED AT EVANSVILLE, INDIANA _____ BY: _____

