

American Health & Life Insurance Company

Administrator For:

Merit Life Insurance Co.
P.O. Box 2548 Fort Worth, TX 76113-2548
Toll Free 800-307-0048 | Fax 800-350-9306
inspolicysvcs@omf.com

Insured's Name	Account/Policy #	SS	SN				
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Change of Policy/Certific		la an analda na abana a a ta th	and the state of hints. This was				
CHANGE OF NAME A copy of legal include one of the following: marriage received without proper documentation	e license, birth certificate, dr						
Change name of Insured FROM	<u> </u>	Change name of Insured TC)				
Reason for change Marriage	Divorce Correction	Other					
CHANGE OF DATE OF BIRTH A This may include one of the following Forms received without proper docum	: marriage license, birth cer	tificate, drivers license, cour					
///		Spouse (optional)					
MM DD	CCYY	N	MM DD CCYY				
CHANGE OF MAILING ADDRESS OR PHONE NUMBER							
Mailing address			Phone Number				
CHANGE OF SMOKER STATUS	Select One						
I affirm that I do <u>not</u> use Tobacco p	roducts and that I have not u	sed Tobacco products in the	e last 12 months.				
I affirm that I do not use Tobacco products and that I have not used Tobacco products in the last 12 months and I did not use							
tobacco products on the date of the original application for coverage.							
CHANGE OF GENDER							
Change of gender FROM		Change of gender <u>TO</u>					
CHANGE OF PAYMENT METHO	D Select One						
☐Direct Bill ☐Monthly	Quarterly	Semi-annually	☐ Annually				
	edit Card Number	· · · · · · · · · · · · · · · · · · ·	Expiration date				
			//				
_		-	MM DD YY				
Electronic Funds Transfer (Automatic Monthly Bank Withdrawal) - Must complete PREAUTHORIZED CHECK FORM							
Signature of Primary Insured or Owne	<u> </u>		Date				
,							

See reverse side for preauthorized check form



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PREAUTHORIZED CHECK FORM FOR THE PURPOSE OF HONORING CHARGES INITIATED BY THE COMPANY TERMS OF AGREEMENT I have an account at the Financial Institution noted on the enclosed voided check, and the account number is shown below. I have sufficient funds to pay for all debit entries. I authorize the Company to make premium payments for the above listed policy/certificate, using electronic bank drafts drawn on this account. I understand that electronic debit entries will evidence the premiums paid for the above-listed policy/certificate, and the entries will constitute my receipt for the transaction(s). No payment to the Company will be deemed to have been made unless and until the Company receives actual credit. I understand my direct electronic payment of the monthly premium will be debited on or about the premium due date. The Company reserves the right to refuse or terminate electronic payment services. This authorization is to remain in effect until the Company terminates it or receives my notification of its termination and has sufficient time to act on it.						
ACCOUNT INFORMATION (Please Print))					
Bank Routing Number						
Bank Account Number						
Name of Account Holder						
Phone Number of Insured						
Signature of Bank Account Holder (as it appear	ars on bank records)		Date			
If you have recently made a payment by check or money order, please indicate the date and amount of the payment.						
Date	_	Amount				
FOR CHECKING ACCOUNTS, ATTACH A VOIDED CHECK						

FOR SAVINGS ACCOUNTS, ATTACH BANK DOCUMENT ACCOUNT VERIFICATION