

Insured's Name \_\_\_\_\_ Policy # \_\_\_\_\_ SSN \_\_\_\_\_

## Change of Policy/Certificate Request Form

**CHANGE OF NAME** A copy of legal documentation is required when making changes to the name or date of birth. This may include one of the following: marriage license, birth certificate, drivers license, court documents or a divorce decree. Forms received without proper documentation will not be processed.

Change name of Insured <b>FROM</b>	Change name of Insured <b>TO</b>
Reason for change <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Correction <input type="checkbox"/> Other _____	

**CHANGE OF DATE OF BIRTH** A copy of legal documentation is required when making changes to the name or date of birth. This may include one of the following: marriage license, birth certificate, drivers license, court documents or a divorce decree. Forms received without proper documentation will not be processed.

<input type="checkbox"/> Insured	____ / ____ / ____	<input type="checkbox"/> Spouse (optional)	____ / ____ / ____
	MM DD CCYY		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 not use Tobacco products and that I have not used Tobacco products in the 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 <b>FROM</b>	Change of gender <b>TO</b>

**For California residents only:** Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signature of Primary Insured or Owner	Date

See reverse side for preauthorized check form

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## AUTHORIZATION TO CHARGE FOR INSURANCE PREMIUMS

<input type="checkbox"/> Direct Bill	<input type="checkbox"/> Monthly	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Semi-annually	<input type="checkbox"/> Annually
<input type="checkbox"/> Credit Card (Automatic Monthly Billing)		Credit Card Number		Expiration date
-		-		MM / DD / YY
<input type="checkbox"/> Electronic Funds Transfer (Automatic Monthly Bank Withdrawal) - Must complete <b>PREAUTHORIZED CHECK FORM</b>				

## 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 appears on bank records)	Date
Signature of Primary Insured or Owner	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**

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