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

☐ **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: _____