Lumico
life insurance

Policy Number: _____

Home Office: 237 E High Street, Jefferson City MO 65101 • Administrative Office: PO BOX 83303, LINCOLN, NE 68501-3303
For Service Call: (866) 440-4047

LIFE CUSTOMER SERVICE REQUEST

☐ SECTION A – NAME AND ADDRESS

Change Name of Insured:

From: _____

To: _____

Because of: _____

Change of Address:

_____

_____

☐ SECTION B – CHANGE OF BENEFICIARY

All previous beneficiary designations are hereby revoked. The following are designated as beneficiaries under the policy. (Give full name, address, date of birth and relationship to insured.)

Primary:

_____

_____

_____

Contingent:

_____

_____

_____

☐ SECTION C – CHANGE OF PAYOR

(If other than owner or insured)

Full Name: _____

Address: _____

_____

Date of Birth: _____

Social Security No: _____

Relationship to Insured: _____

Phone Number: _____

Please note: The payor name that appears here must match the name/signature given on the Payment Authorization.

☐ SECTION D – CHANGE PREMIUM MODE/METHOD

If Payor change, complete Section C.

Change Premium Mode to: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

Change Payment Method to:

Cardholder/Account Name: _____

Card Type/Account Type: _____

Account Number: _____

Expiration Date: _____

Payment Authorization: I authorize the premium to be processed and remitted to the Lumico Life Insurance Company through my credit card/bank account as referenced herein. The authority is in effect until I cancel it in writing and until the Company or my credit card/bank account actually revokes such notice.

_____

Authorized Signature Date

☐ SECTION E – CHANGE OF OWNER

Owner: _____

(if other than insured – give full name, address & relationship to insured.)

Owner is:

☐ Individual

☐ Trustee

Business:

☐ Sole Proprietorship

☐ Partnership

☐ Corporation

(Name of trust & date of trust agreement)

_____

Business Entity, Name of Principle:

_____

Contingent Owner:

(to succeed the rights of the owner on his or her death, otherwise ownership will pass to the insured. Give full name, address & relationship to insured)

_____

_____

☐ SECTION F – TOTAL SURRENDER

The policy is surrendered for payment of the net cash value.

☐ The policy is attached ☐ The policy has been lost or destroyed

☐ SECTION G – POLICY LOAN

Process loan in the following amount:

☐ Maximum Amount

☐ $ _____ Amount Requested

☐ SECTION H – AUTOMATIC PREMIUM LOAN

Remove policy premiums from being paid by Automatic Premium Loan.

☐ SECTION I – DECREASE IN COVERAGE

From (Amount): _____

To (Amount): _____

Note: Signed written notice of release acceptable to the Company from a collateral assignee is required to be attached to this form.

☐ SECTION J – PLAN CHANGE (within 90 days of issue)

If increasing, complete Statement of Insurability.

Policy Required. Proposal Required

From (Plan): _____ (Amount): _____

To (Plan): _____ (Amount): _____

☐ SECTION K – DUPLICATE POLICY

The policy was lost or destroyed. If the original policy is found later I will return it to the Company. This statement is made for the purpose of procuring a duplicate of said policy.

☐ SECTION L – PREFERRED RATES

Complete Statement of Insurability.

☐ SECTION M – ADD OR CHANGE RIDER(S)

Add: (*Complete Statement of Insurability*)

☐ Accidental Death Rider (Same face amount as policy)

☐ Dependent Child Rider Specified Amount: _____

Change: (Dependent Child Rider)

Complete Statement of Insurability if increasing amount.

☐ Decrease Specified Amount to: _____

☐ Increase Specified Amount to: _____

☐ SECTION N – SETTLEMENT VALUES OPTIONS

If request settlement under my policy be.

☐ **Interest Income** ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

☐ **Income Fixed Period** Number of Years: _____

☐ **Life Income**

☐ **Life Income Period Certain** ☐ 10 Years ☐ 15 Years ☐ 20 Years

☐ **Income Fixed Amount** Amount: _____

☐ SECTION O – REINSTATEMENT

Complete Statement of Insurability

☐ SECTION P – POLICY VALUES OPTION

I request my policy be placed on Reduced Paid-Up Insurance.

☐ SECTION Q – REMOVE RIDERS

☐ Accidental Death Rider ☐ Dependent Child Rider

Owner's Statement and Signature

I hereby request the changes identified in this completed Life Customer Service Request Form. I represent that all information provided is true, correct and complete to the best of my knowledge and belief.

I understand that the effective date of the changes requested: (a) which **DO NOT REQUIRE** a Statement of Insurability will be, unless otherwise indicated in the policy, the date this signed Life Customer Service Request Form is received by the Administrative Office of the Company; and (b) which **DO REQUIRE** a Statement of Insurability will be as described in the Insured Representations, Authorizations and Signatures for Statement(s) of Insurability section of this Life Customer Service Request Form.

I understand that any changes will not apply to any payment or action taken by the Company before it receives a copy of this signed form at its Administrative Office.

FRAUD NOTICE: It is a crime to knowingly provide false, incomplete or misleading information to an Insurance Company for the purpose of defrauding the Company. Penalties include imprisonment, fines and denial of insurance benefits.

_____ _____

Owner Signature Date