FAMILY BENEFIT LIFE INSURANCE CO.

ADMINISTRATIVE OFFICE:
PO Box 5205 | Frankfort KY 40602-5205
Phone: 866.440.1357 **Fax:** 502.875.7084

REQUEST FOR CHANGE

INSURED'S FULL NAME: **POLICY NO:**

OWNER'S NAME:

ADDRESS (IF CHANGED) :

PHONE NUMBER(S) OR EMAIL ADDRESS :

PLACE "X" IN BLOCKS FOR DESIRED CHANGE FOLLOW ANY DIRECTIONS.
SIGN AND DATE AT BOTTOM OF FORM

NOTICE: THIS FORM CANNOT BE USED FOR THE FOLLOWING CHANGES.
PLEASE CONTACT OUR ADMINISTRATIVE OFFICE FOR:

1. Name change Forms (Insured, Beneficiary or Owner)
2. Beneficiary Change Form
3. Correction of age Form
4. Ownership change Form

☐ **LOST POLICY OR GROUP CERTIFICATE**

☐ **REQUEST FOR SUMMARY CERTIFICATE:** I certify that the original policy numbered above has been lost or destroyed, that a diligent search has been made and that its existence or whereabouts is unknown. In consideration of the granting of this request, I undertake and agree as follows: (1) that the Summary Certificate issued in accordance with this request shall stand in the place and stead of the original policy for all purposes; (2) that all of the terms and conditions of the original policy shall remain in force and effect as evidenced by this Summary Certificate; that I will save the Company harmless from all loss or injury which may occur as a direct or indirect result of its act of issuing this Summary Certificate; and that if the original policy is found, it shall be placed with this Summary Certificate.

☐ **REQUEST FOR COMPLETE DUPLICATE OF POLICY OR GROUP CERTIFICATE ($35.00 Fee):** I certify that the original policy numbered above has been lost or destroyed, that a diligent search has been made and that its existence or whereabouts is unknown.

☐ **CHANGE MODE OF PREMIUM PAYMENT:** ☐ ANNUAL ☐ SEMI-ANNUAL ☐ MONTHLY PAT *(Attach new PAT card and voided check)*

AMOUNT OF NEW PREMIUM: $_____

☐ **CHANGE NAME AND ADDRESS OF PERSON RECEIVING PREMIUM BILLING:**

Name: _____

Address _____

City, State, Zip: _____

☐ **CHANGE PLAN OF INSURANCE OR AMOUNT OF INSURANCE:** ***(Return Policy for Endorsement)***

☐ From Plan: _____ To Plan: _____

☐ From Amount: $_____ To Amount: $_____ Premium: $_____

BENEFICIARY: _____ Relationship: _____

PREMIUM PAYMENT MODE:

☐ ANNUAL ☐ SEMI-ANNUAL ☐ MONTHLY PAT-(Attach new PAT card and voided check)

☐ **OTHER REQUESTS:**

DATE: _____ X _____
Signature of **Owner of Policy** (Always Required)

WITNESS: X _____ X _____
(IF AGENT INCLUDE AGENT NUMBER) ASSIGNEE SIGNATURE IF APPLICABLE

X _____
SPOUSE'S SIGNATURE (REQUIRED IN COMMUNITY PROPERTY STATES – CURRENTLY AZ, CA, ID, LA, NM, NV, TX, WA AND WI