USAble Life

P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone (501) 375-7200

REQUEST FOR CHANGE AND DUPLICATE POLICY REQUEST

Name of Policyholder: _____ Policy Number: _____

Social Security #: _____ Group #: _____

Current Address: _____ City: _____ State: _____ Zip: _____

If payment is made through Payroll Deduction,
please enter Employer or Group Name: _____

Please make the following changes to my Policy:

☐ **NAME CHANGE**

Name Shown on Policy _____
Change Name To _____
Reason _____
Effective Date of Name Change _____

☐ **ADDRESS CHANGE**

New Address _____
_____
Phone _____

☐ **DELETIONS**

Person to be Deleted _____ Relationship _____
Birthdate of Person to be Deleted _____ Effective Date of Deletion _____
New Policyholder's Full Name _____ Reason for deletion: ☐ Death ☐ Marriage ☐ No longer dependent
Social Security # _____ Birthdate of New Policyholder _____
Type of Coverage now desired ☐ Individual ☐ Family ☐ Applicant & Children
New Monthly Premium $ _____

☐ **CONTINUATION OF COVERAGE FOR HANDICAPPED DEPENDENTS**

I am advising you that the following dependent is incapable of self support by reason of mental or physical handicap as defined in the policy and is eligible for continuation of coverage:

Full Name **Date of Birth** **Relationship**

_____

☐ **CANCELLATION OF RIDER**

I hereby request that the following Rider(s) attached to the policy referenced above be cancelled effective _____:

_____ _____
_____ _____

☐ **REQUEST FOR DUPLICATE POLICY**

I hereby declare that the Policy referenced above has been lost or destroyed, and I have no knowledge of its whereabouts. I request issuance of a duplicate policy.

_____ _____ _____
Date **City** **State**

_____ _____
Witness to Signature **Insured's Signature**