Administrative Address
PO Box 17628, Winston-Salem, NC 27116
Toll-Free: (833) 658-2844
Fax: (336) 464-2664
Email: SupphealthService@lbig.com

Liberty Bankers®
Insurance Group | *Liberty Bankers Life*

Policyholder Service Request Form

POLICYHOLDER NAME:	POLICY NUMBER:

Change of Address

NEW MAILING ADDRESS:

CITY:	STATE:	ZIP:

Change of Name

(For name changes due to marriage, provide a copy of government issued ID with new name or marriage certificate. For all other changes, provide a copy of court decree)

FROM:

TO:

Change of Beneficiary

NAME OF NEW BENEFICIARY	DOB	SSN	PRIMARY OR CONTINGENT	PERCENTAGE (Total for all beneficiaries combined must equal
1.				
2.				
3.				

Premium Billing Change

BANK DRAFT (M, SA, A) CREDIT CARD (M) LISTBILL (M) DIRECT BILL (SA, A)

PREMIUM MODE: MONTHLY SEMI-ANNUALLY ANNUALLY

Bank Draft Information

BANK NAME:

ROUTING #:	ACCOUNT #:

Debit/Credit Card Information

DEBIT/CREDIT CARD #:	EXP. DATE:

NAME AS IT APPEARS ON CARD:

Card Billing Address

CITY:	STATE:	ZIP:

TELEPHONE NUMBER:

Bank Draft, Credit/Debit Card Authorization

I authorize Liberty Bankers Life Insurance Company to withdraw funds from my account or change my debit/credit card for my renewal premiums at the frequency indicated by the premium mode selected above. I further authorize my financial institution to pay any preauthorized electronic fund transfers from my account or change my debit/credit card to Liberty Bankers Life Insurance Company. I understand this authorization will be in effect until I give written notice, at least five business days in advance of a scheduled withdrawal, of my intent to cancel electronic bank draft or debit/credit card payments.

Policyholder Service Request Form

Duplicate Policy Request

Cancel Policy

Nicotine user to Non-nicotine user (Complete attached questionnaire)

Adding dependents (including newborns and adopted)

NAME OF DEPENDENT	SEX (M/F)	DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NUMBER	DEPENDENT (NEWBORN OR ADOPTED)
1.				
2.				
3.				

Continuing Coverage for Dependent over Age 26 (with disability)

Complete attached questionnaire.

Conversion (due to Dissolution of Marriage, Domestic Partnership, or Civil Union.)

Complete new application for spouse to convert to a new policy.

Decreasing Benefits or Removing Riders

Note: Increasing or adding requires a new application submitted for underwriting review.

Decreasing Benefits on Base Plans

BASE PLAN	CURRENT BENEFIT AMOUNT	NEW BENEFIT AMOUNT REQUESTED
Hospital Indemnity Base Plan		
Accident Base Plan		
Cancer Base Plan		
Heart and Stroke Base Plan		
Critical Care Base Plan		

Removing Riders

- Hospital Indemnity Rider
- Accident Rider
- Cancer Rider
- Heart and Stroke Rider
- Critical Care Rider
- Ambulance Services Rider
- Emergency Room/Urgent Care Rider
- Outpatient Therapy and Medical Devices Rider
- Dental, Vision and Hearing Rider
- Skilled Nursing Facility/Hospice Care Rider
- Skilled Nursing Facility with Elimination Period/Hospice Care Rider
- Lump Sum Hospital Confinement Rider
- Outpatient Surgery Rider
- Outpatient Diagnostic Serices Rider
- Return of Premium Upon Death Rider
- Accident Recovery Income Rider
- Hospital Indemnity Automatic Increase Rider

Insured Printed Name: _____ Date: _____

Signature: _____