

Policyholder Service Request Form: Supplemental Health

POLICYHOLDER NAME:	POLICY NUMBER:
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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 <small>(Total for all beneficiaries combined must equal 100%)</small>
1.				
2.				
3.				

Premium Billing Change

<input type="checkbox"/> BANK DRAFT (M, SA, A)	<input type="checkbox"/> CREDIT CARD (M)	<input type="checkbox"/> LISTBILL (M)	<input type="checkbox"/> DIRECT BILL (SA, A)
PREMIUM MODE: <input type="checkbox"/> MONTHLY (M) <input type="checkbox"/> SEMI-ANNUALLY (SA) <input type="checkbox"/> ANNUALLY (A)			

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 charge 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 charge 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.

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Duplicate Policy Request

Cancellation Request

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
<input type="checkbox"/> Hospital Indemnity Base Plan		
<input type="checkbox"/> Accident Base Plan		
<input type="checkbox"/> Cancer Base Plan		
<input type="checkbox"/> Heart and Stroke Base Plan		
<input type="checkbox"/> Critical Care Base Plan		

Removing Riders

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

Insured Printed Name: _____

Date: _____

Signature: _____