LifeSecure®

Change Request Form
(for Policies Beyond 90 Days of Issue Date)

Required Information:

Policy #: _____ _____
Date of Birth

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. (check one)

_____ ____ _____
Name (First) (MI) (Last)

☐ Check here if address is new.

_____ _____
Street Address Apt. #

_____ _____ _____
City State Zip Code

Benefit Bank Decrease:

Decrease Benefit Bank amount to: $ _____

Note: You may decrease your Benefit Bank to a dollar amount no less than $75,000*.

* In IN, the minimum Benefit Bank amount is $140,000.
* In SD, Benefit Bank amounts less than $300,000 require either 2% or 3% Monthly Benefit Access Limit.
* In WI, Benefit Bank amounts less than $180,000 require either 2% or 3% Monthly Benefit Access Limit.

Miscellaneous Policy Changes:

☐ **"Protection Against Unintended Lapse or Termination" – Authorized Designee**

I understand that I have the right to designate at least one authorized person, other than myself, to receive notice of lapse or termination of this long term care coverage due to nonpayment of premium. I understand that notice will not be given to this person until 35 days after a premium is due and unpaid.

☐ I elect to designate another person to receive this notice.

_____ ____ _____
Name of Authorized Person (First) (MI) (Last)

_____ _____
Street Address Apt. #

_____ _____ _____ _____
City State Zip Code Phone Number

☐ **Beneficiary**

Please note: If no beneficiary is named, the default beneficiary will be your estate.

_____ _____
Name of Primary Beneficiary Contingent Beneficiary

_____ _____
Relationship Relationship

_____ _____
Street Address Street Address

_____ _____
City State Zip City State Zip

☐ **Policy Cancellation**

I choose to cancel my policy. Please cancel my policy effective _____
(Month/Day/Year)

Policyholder Information Changes:

☐ **Change of Legal Name**

The reason for this change is (check one): ☐ Marriage ☐ Divorce ☐ Other

Former Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr.

_____ ____ _____
Name (First) (MI) (Last)

New Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr.

_____ ____ _____
Name (First) (MI) (Last)

☐ **Address Change** — Please print your NEW address below:

_____ _____
Street Address Apt. #

_____ _____ _____
City State Zip Code

☐ **Telephone Number Change** — Please print your NEW telephone number(s) below:

( ) – ( ) –
Work Phone Number Home Phone Number

Would you prefer to receive future communications in hard-copy format via U.S. mail OR electronically via e-mail (pdf)?

☐ Hard-copy ☐ E-mail (pdf)

☐ **E-mail Address Change** — Please print your NEW e-mail address below:

_____
E-mail Address

I hereby declare that I understand the nature of the changes requested above and that the information stated above is true and complete to the best of my knowledge and belief. I agree that any change will become effective on the date set by LifeSecure following receipt and approval of this request.

Signature:_____ **Date:**_____

FAX or MAIL completed form to:

FAX: 1.850.438.8478
MAIL: LifeSecure Administrative Office, P.O. Box 12834, Pensacola, FL 32591