



Date Received
---------------

## REQUEST FOR CHANGE FORM

(Please complete a separate form for each life insurance account except for sections 2 and 3.)

Account Number	Product Type	Insured	Owner (If other than insured)
----------------	--------------	---------	-------------------------------

### 1. CHANGE OF BENEFICIARY

I hereby revoke any previous designation of beneficiaries and request that the life insurance benefit payable at my death be paid in accordance with the designations below. If more than one beneficiary is designated in the same beneficiary class, payment shall be made in equal shares to the designated beneficiaries in the beneficiary class who survive me unless otherwise provided herein. To comply with the laws of your state, we must be informed of any legal restrictions affecting your beneficiary designations. **Note:** Beneficiary changes on 5Star Life Insurance Company ("5Star Life") forms, and not those changes contained in an insured's will or trust or other writing or agreement, shall govern in all cases of change.

If you wish to make a designation irrevocable, please contact the Administrative Offices for instructions.

#### *Primary Beneficiary*

Full Name (First, Middle, Last) \_\_\_\_\_ Relationship \_\_\_\_\_

Date of Birth (MM/DD/YYYY) \_\_\_\_\_ SSN \_\_\_\_\_

Phone Numbers (including Area Code): Daytime \_\_\_\_\_ Cell \_\_\_\_\_ Evening \_\_\_\_\_

Complete Address (including Zip Code — No PO Boxes) \_\_\_\_\_

I have named additional beneficiaries for this class. Attach separate sheet with your name, account number, signature and date.

#### *Contingent Beneficiary*

Full Name (First, Middle, Last) \_\_\_\_\_ Relationship \_\_\_\_\_

Date of Birth (MM/DD/YYYY) \_\_\_\_\_ SSN \_\_\_\_\_

Phone Numbers (including Area Code): Daytime \_\_\_\_\_ Cell \_\_\_\_\_ Evening \_\_\_\_\_

Complete Address (including Zip Code — No PO Boxes) \_\_\_\_\_

I have named additional beneficiaries for this class. Attach separate sheet with your name, account number, signature and date.

### 2. CHANGE OF NAME

I elect to change the name of the  Insured  Owner  Payor to the following:

Name before change \_\_\_\_\_

Name after change \_\_\_\_\_

Date of change \_\_\_\_\_

Reason for change:  Marriage  Divorce  Adoption  Other: \_\_\_\_\_

Account Number	Product Type	Insured	Owner (If other than insured)
----------------	--------------	---------	-------------------------------

**3. CHANGE OF ADDRESS**

Insured  Owner  Payor

Complete Address (including Zip Code) \_\_\_\_\_

Phone Numbers (including Area Code): Daytime \_\_\_\_\_ Cell \_\_\_\_\_ Evening \_\_\_\_\_

Email Address \_\_\_\_\_

**4. OWNERSHIP CHANGE**

I elect to change the owner of this certificate/policy to the following individual and understand that all benefits, rights, and privileges incident to ownership of this certificate/policy will be vested in the new owner.

New Owner (First, Middle, Last) \_\_\_\_\_ Relationship \_\_\_\_\_

Contingent Owner (in the event owner predeceases insured) \_\_\_\_\_

Date of Birth (MM/DD/YYYY) \_\_\_\_\_ SSN \_\_\_\_\_

Phone Numbers (including Area Code): Daytime \_\_\_\_\_ Cell \_\_\_\_\_ Evening \_\_\_\_\_

Complete Address (including Zip Code) \_\_\_\_\_

Signature of New Owner \_\_\_\_\_

Please Note: The CURRENT owner MUST sign below to request this ownership change.

The current owner's spouse must also sign if current owner lives in a community property state (AK, AZ, CA, ID, LA, MT, NV, NM, PR, TX, UT, VT, WA).

Spouse's Signature \_\_\_\_\_

**5. REQUEST TO DECREASE COVERAGE**

(Not applicable for Group, Individual, or Executive Select Term. Please contact us with questions.)

I \_\_\_\_\_, owner of this certificate/policy would like to decrease my coverage amount to \$ \_\_\_\_\_

**6. LOST STATEMENT COVERAGE REQUEST**

Please send Statement of Insurance Coverage.

Please send complete duplicate certificate/policy.

Reason for request  Cannot locate  Never received  Other \_\_\_\_\_

**SIGNATURES**

Sign and date this form and forward to 5Star Life. We will acknowledge receipt by returning a date stamped copy to you.

Signature of Insured \_\_\_\_\_ Date \_\_\_\_\_

Parent or guardian, if insured is a minor

Signature of Owner \_\_\_\_\_ Date \_\_\_\_\_

Required if other than Primary Insured

Owner's Name (Please Print) \_\_\_\_\_

Phone Numbers (including Area Code): Daytime \_\_\_\_\_ Cell \_\_\_\_\_ Evening \_\_\_\_\_

Owner's Complete Mailing Address \_\_\_\_\_