



LIFESECURE INSURANCE COMPANY
 ADMINISTRATIVE OFFICE
 P.O. Box 1019
 Brighton, MI 48116-1019
 PH: 888.575.8246

CHANGE REQUEST FORM

(FOR HOSPITAL RECOVERY & PERSONAL ACCIDENT POLICIES AFTER ISSUE)

REQUIRED IDENTIFICATION INFORMATION: (Print clearly – Use black or blue ink.)			
Policy Number:		Date of Birth:	
Name:		Last 4 of SSN:	
Address 1:		Address 2:	
City:		State:	
Zip:		Phone:	
Home Phone:		Work Phone:	
Email Address:			
Please <input checked="" type="checkbox"/> the highlighted boxes to indicate new or updated information. <i>Note: Contact information will cause updates to all of your policies.</i>			

CHANGE OF LEGAL NAME:

The reason for this change is (check one):	<input type="checkbox"/> Marriage	<input type="checkbox"/> Divorce	<input type="checkbox"/> Other
---	-----------------------------------	----------------------------------	--------------------------------

Title:	<input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	<input type="checkbox"/> Miss	<input type="checkbox"/> Dr.
First name:		MI		Last name:	

BENEFIT CHANGES:

Personal Accident Policy:

- Increase Annual Benefit Amount to: \$ _____
 Note: You may increase your Benefit Bank in increments of \$100 to an amount no more than \$15,000 for individuals or \$25,000 for couples and families.
- Decrease Annual Benefit Amount to: \$ _____
 Note: You may decrease your Benefit Bank in increments of \$100 to an amount no less than \$2,500.

Hospital Recovery Policy:

Note: Benefit Increases and the addition of optional policy riders require the completion of a new Application form. The forms are available by contacting Policyholder Support at 1-888-575-8246.

- Decrease Daily Benefit Amount to: \$ _____
 (any amount between \$100-\$900 and in increments of \$100)
- REMOVE - EMERGENCY ROOM TREATMENT RIDER
- REMOVE - MAJOR DIAGNOSTIC EXAM RIDER
- REMOVE - REHABILITATION RIDER

ADD OR REMOVE FAMILY MEMBERS FROM COVERAGE:

- Remove Spouse / Domestic Partner** (Checking this box will remove the spouse rider)
- Add Spouse / Domestic Partner** (Please review your policy for spousal age limitations)

Title:	<input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	<input type="checkbox"/> Miss	<input type="checkbox"/> Dr.	Date of Birth:	
First name:				MI		Last name:	

- Remove Child Rider** (Checking this box indicates there are no eligible dependents or you no longer want this Rider)
- Add Children**

Note: Children must be under age 26.

First name:		MI		Last name:		Date of Birth:	
First name:		MI		Last name:		Date of Birth:	
First name:		MI		Last name:		Date of Birth:	
First name:		MI		Last name:		Date of Birth:	

POLICY CANCELLATIONS:

Hospital Recovery Policy

- Please cancel my policy effective _____.
- Please cancel my policy as of my current paid to date.

Personal Accident Policy

- Please cancel my policy effective _____.
- Please cancel my policy as of my current paid to date.

UNEARNED PREMIUM REFUND CHOICE:

If the change you requested results in a refund of unearned premium, please designate refund handling:

- Apply my unearned premium refund to reduce future premium payments.**
- My requested policy changes (Benefit Bank decrease or removal of optional benefits/riders) should be made effective upon my next premium due date resulting in no unearned premium due to me.**
- Refund the balance of unearned premium directly to me.**

SIGNATURE REQUIRED

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: 877.226.0925 **MAIL:** LifeSecure Administrative Office, P.O. Box 1019, Brighton, MI 48116-1019

For questions on this form or your current coverage, please call: 888.575.8246.