Print Form | Save Form

LIFESECURE INSURANCE COMPANY
ADMINISTRATIVE OFFICE
P.O. Box 12834
Pensacola, FL 32591

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 ☑ the gray boxes to indicate new or updated information.

Note: Contact information will cause updates to all of your policies.

CHANGE OF LEGAL NAME:

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

Title: ☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** ☐ **Miss** ☐ **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 Services 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: ☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** ☐ **Miss** ☐ **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, unless it is a qualified disabled dependent which requires an additional form.

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