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

LONG TERM CARE CHANGE FORM

(FOR ISSUED POLICIES THAT ARE AT LEAST 90-DAYS AFTER THE APPLICATION SIGNATURE DATE)

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 changes will cause updates for all of your policies.*			

ADMINISTRATIVE CHANGES:

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:			

Spouse/Domestic Partner Status Change:

Title:	Mr.	Mrs.	Ms.	Miss	Dr.		
First name:		MI		Last name:			
Spouse / Partner SSN (required):							

MISCELLANEOUS LONG TERM CARE POLICY CHANGES:

Beneficiary: If no beneficiary is named, the default beneficiary will be your estate.
Lapse Designee: You have the right to designate at least one authorized person, other than yourself, to receive notice of lapse or termination of this long term care coverage due to nonpayment of premium. This notice will not be given to this person until 30 days after a premium is due and unpaid.

Primary Beneficiary	Contingent Beneficiary	Lapse Designee	CHANGE	or	ADDITION

First Name:		Last Name:	
Address 1:		Address 2:	
City:		State:	
Zip:		Phone:	

☐ Primary Beneficiary	☐ Contingent Beneficiary	☐ Lapse Designee	☐ CHANGE or ☐ ADDITION
First Name:		**Last Name:**	
Address 1:		**Address 2:**	
City:		**State:**	
Zip:		**Phone:**	

Note: For additional Beneficiaries or Lapse Designees, please submit additional pages or letter of intent. If you do not select 'Change' or 'Addition' the option will default to Change.

REINSTATEMENT REQUEST:

☐ **REINSTATEMENT DUE TO UNINTENTIONAL LAPSE BECAUSE YOU WERE CHRONICALLY ILL:**

Reinstatement requires proof that you were Chronically Ill before the Grace Period. The proof must be in the form of a certification and assessment from a Licensed Health care Practitioner which demonstrates that You were Chronically ill. The proof must be provided to Us within five months of the termination date.
PROOF AND THIS FORM MAY BE FAXED TO **877.226.0925.**

POLICY CANCELLATION:

☐ I choose to cancel my Long Term Care insurance policy.

BENEFIT CHANGES:

Please place an "X" or check mark in the box next to the desired change(s).
Notes: If you have a Shared Care Rider, both policies must have identical coverage.
Changes to a 10-Pay coverage plan are not allowed on existing policies.

☐ **MONEY-BACK PROMISE – REMOVE**
☐ **AUTOMATIC COMPOUND INFLATION PROTECTION – REMOVE**
☐ **AUTOMATIC COMPOUND INFLATION PROTECTION – DECREASE FROM 5% TO 3%**
☐ **SHARED CARE– REMOVE**
☐ **BENEFIT BANK DECREASE:***
Decrease Benefit Bank amount to: $ _____
*Minimum Benefit limitations may apply – please call 888.575.8246

OTHER BENEFIT CHANGES:

Benefit changes not associated with the above decreases in coverage **REQUIRE** the completion of a new Application form and underwriting review. If approved, your revised premium will reflect your current age and underwriting will consider your current health status.

The Application is available by contacting Policyholder Services at 888.575.8246.

PREMIUM REFUNDS HANDLING:

If the change(s) you requested results in a refund of (unearned) premium, please select one of the options below.

☐ **Refund unearned premium to me.**

Checking this box indicates that I understand this refund request may cause my policy to no longer qualify for federal income tax advantages. Under Federal Law, any unearned premium refunded in cash, other than upon the death of the insured or the complete surrender or cancellation of the policy, may disqualify your policy from further federal income tax advantage. To the extent your premium was previously deducted for tax purposes, this refund may be taxable. You should contact your tax advisor for more information.

☐ **Apply unearned premium refund to reduce future premiums.**

I understand this request will not result in a cash refund to me, but will reduce future premium.

NOTE: In general, requested policy changes will be made effective upon the next monthly anniversary of the policy effective date resulting in no unearned premium due.

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.