Administrative Office: PO Box 25968, Oklahoma City OK 73125

Change Request Form

Policy Number: _____ Insured Name: _____

I request the following changes and/or services as follows:

Please place a check mark next to the changes being made.

☐ **CHANGE OF BENEFICIARY**

I hereby revoke any previous designation of beneficiaries and now direct that in the event of death of the Insured hereunder the proceeds of this policy shall be paid to:

Primary Beneficiary

Name	Relationship to Insured	Date of Birth	Social Security Number
Address			

Name	Relationship to Insured	Date of Birth	Social Security Number
Address			

If the primary beneficiary/ies is/are not living at the date of death of the Insured, we will pay the Contingent Beneficiary.

Contingent Beneficiary

Name	Relationship to Insured	Date of Birth	Social Security Number
Address			

Name	Relationship to Insured	Date of Birth	Social Security Number
Address			

☐ **CHANGE OF ADDRESS AND/OR PHONE NUMBER**

The address change is for: ☐ Insured ☐ Owner ☐ Payor

New address	New phone number

☐ **CHANGE OF NAME**

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

*Please provide a legal document for any name change.

Name before change	
Name after change	Date of change

Reason for change ☐ Marriage ☐ Divorce ☐ Adoption ☐ Other: _____

☐ **CHANGE OF OWNERSHIP**

I hereby transfer all rights of ownership in this policy and agree that he/she will have the privilege of exercising every right or option granted by this policy without my consent.

NOTE: The CURRENT owner must sign below to request the ownership change.

Name of New Owner	Social Security Number
Address of New Owner	
Signature of New Owner	Relationship

☐ **CHANGE OF PAYOR**

This person will receive all bills for coverage.

New Payor
Address of new payor

☐ **REQUEST OF DUPLICATE/LOST POLICY**

Reason for request: ☐ Cannot locate ☐ Never received ☐ Other: _____

☐ **DECREASE IN COVERAGE**

Policy Number: _____ (If coverage is to be increased, a new application is required.)

Benefit amount from: $_____ to: $_____

Decrease coverage for: ☐ Spouse ☐ Child ☐ Other: _____

Specific details/instructions_____

_____

☐ **REQUEST TO CANCEL COVERAGE**

I, _____, owner of the above policy would like to cancel the above-referenced policy.

☐ **OTHER**

_____

_____

Signature of Owner: _____ Date: _____

Signature of Insured:_____ Date: _____

Owner's mailing address: _____

For company use only

The change(s) above have been acknowledged, accepted, and recorded by AFR Life Insurance Company.

By: _____ Date: _____