AFR LIFE

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Change Request Form

Policy Number: Insured Name:

Please place a checkmark next to the changes being made. I request the following changes and/or services:

☐ Change of Beneficiary

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

PRIMARY BENEFICIARY

Name:		Date of Birth:
Relationship to Insured:		Social Security:
Address:		
City:	State:	Zip:

If the primary beneficiary(ies) is not living at the date of death of the Insured, we will pay the Contingent

CONTINGENT BENEFICIARY

Name:		Date of Birth:
Relationship to Insured:		Social Security:
Address:		
City:	State:	Zip:
Name:		Date of Birth:
Relationship to Insured:		Social Security:
Address:		
City:	State:	Zip:

☐ Change of Address and/or Phone Number

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

New Phone Number:

New Address:

City:	State:	Zip:

☐ Change of Name

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

Name Before Change:

Name After Change:	Date of Change:

Reason For Change: ☐ Marriage ☐ Divorce ☐ Adoption ☐ Other:

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☐ 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:
Relationship to Insured:		
Address:		
City:	State:	Zip:
Signature of New Owner:		

☐ Change of Payor

This person will receive all bills for coverage.

Name of New Payor:		
Address:		
City:	State:	Zip:

☐ 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: