

**REQUEST FOR SERVICE**

Email completed form to [PolicyOwnerService@iaclife.com](mailto:PolicyOwnerService@iaclife.com), fax to (405) 285-0836, or mail to **PO Box 14998, Oklahoma City, OK 73113**

POLICY NUMBER	INSURED	OWNER (If other than insured)																
CHANGE NAME OF: <input type="checkbox"/> Insured <input type="checkbox"/> Owner <input type="checkbox"/> Payer																		
FORMER NAME (please print)	NEW NAME (please print)																	
REASON FOR CHANGE (If other than correction, marriage or divorce, please attach copy of legal evidence; if available.)																		
<input type="checkbox"/> <b>DUPLICATE POLICY REQUEST</b> I hereby declare the original policy has been lost or destroyed. Please issue a duplicate policy if possible or a certificate of insurance. If original policy is located, I promise to return the duplicate to the Company.	<input type="checkbox"/> <b>FULL SURRENDER</b> I request payment of the net cash value in exchange for surrender of this policy. No bankruptcy proceedings are outstanding against me and no liens are pending against the policy except as follows:																	
<input type="checkbox"/> <b>CHANGE OF ADDRESS</b> (Indicate new address)	<input type="checkbox"/> <b>REDUCE COVERAGE ON POLICY/REDUCE PREMIUM</b> I hereby request to reduce my policy face amount to \$ _____, or I hereby request to reduce my policy premium to \$ _____ Payroll Period: _____ Effective: _____																	
<input type="checkbox"/> <b>CHANGE OF TELEPHONE NUMBER</b> (indicate new telephone number)	<input type="checkbox"/> <b>CHANGE OF PAYMENT MODE/AMOUNT</b> <table style="width:100%; border: none;"> <thead> <tr> <th style="text-align: left;"></th> <th style="text-align: right;">New Payment Amount</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Check-O-Matic Monthly</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td><input type="checkbox"/> Direct Bill Monthly</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td><input type="checkbox"/> Direct Bill Quarterly</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td><input type="checkbox"/> Direct Bill Semi-Annually</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td><input type="checkbox"/> Direct Bill Annually</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td><input type="checkbox"/> List Bill Biweekly</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td><input type="checkbox"/> List Bill Semi-Monthly</td> <td style="text-align: right;">\$ _____</td> </tr> </tbody> </table>			New Payment Amount	<input type="checkbox"/> Check-O-Matic Monthly	\$ _____	<input type="checkbox"/> Direct Bill Monthly	\$ _____	<input type="checkbox"/> Direct Bill Quarterly	\$ _____	<input type="checkbox"/> Direct Bill Semi-Annually	\$ _____	<input type="checkbox"/> Direct Bill Annually	\$ _____	<input type="checkbox"/> List Bill Biweekly	\$ _____	<input type="checkbox"/> List Bill Semi-Monthly	\$ _____
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<input type="checkbox"/> <b>CANCELLATION OF RIDERS</b> I hereby request cancellation of the following riders to my policy effective _____. <ul style="list-style-type: none"> <li><input type="checkbox"/> Waiver of Premium</li> <li><input type="checkbox"/> Accidental Death Benefit</li> <li><input type="checkbox"/> Guaranteed Insurability Option</li> <li><input type="checkbox"/> Waiver of Monthly Deduction</li> <li><input type="checkbox"/> Other Insured</li> <li><input type="checkbox"/> Children's Term</li> <li><input type="checkbox"/> Cost of Living</li> <li><input type="checkbox"/> Disability Income Plan</li> </ul>																		
<b>COMPLETE FOR ABOVE REQUEST</b> By signing below, I declare that the information provided herein is true, complete, and correct. I direct that any amendment of the policy requested above take effect on the date this request is signed, but without any liability to the Company on account of payment made or action taken by it before this request was acknowledged by the Company. I agree that the Company may waive any policy provision requiring presentation of the policy for endorsement, but it may require such presentation if desired.																		
_____ Signature of Owner		_____ Date																
The undersigned agrees to the above requests and changes.																		
_____ Signature of Owner's Spouse (If resident of community property state.)	_____ Signature of Assignee (If any.)	_____ Signature of Irrevocable Beneficiary (If any.)																