Policy Service Request

Worksite Solutions division of Combined Insurance Company of America
P.O. Box 1160
Glenview, Illinois 60025-8160
Phone: 1-800-544-9382

☐ **LIFE POLICY** ☐ **HEALTH POLICY** ☐ **ACCIDENT POLICY** ☐ **DISABILITY POLICY**

Insured Name _____

Street Address _____

City _____ State _____ Zip _____

☐ Check here if this is a new address.

Telephone Number ( ) _____ E-mail _____

Policy # _____

Service Requested

☐ Change of Employment — Request Direct Billing: ☐ Semi-Annual ☐ Annual

Please contact Customer Service if you would like premiums drafted from your checking account each month.

☐ Change of Owner

Change Name from _____ to _____
Last First Last First

Reason: ☐ Marriage ☐ Divorce ☐ Adoption ☐ Other _____

☐ Request for Duplicate Policy ☐ Request to Change the Beneficiary
(Please complete the form: **Request for Change of Named Beneficiary**)

☐ Other _____
(Specify Service Requested)

Signature of insured or owner _____ Date _____

Request for Change of Named Beneficiary

In order to change your beneficiary, please sign and date the form below in the presence of a witness. Have the witness also sign the form, and return it in the envelope provided. We will send you a photocopy of the completed form so that you may attach it to the policy.

This request affects only the named beneficiary of the Insurance Policy indicated below, and does not affect any beneficiary designations on other policies you may own.

FULL NAME OF INSURED	POLICY NUMBER(S):
☐ MR. ☐ MRS. ☐ MISS _____ (FIRST / MIDDLE / LAST)	1. _____
OWNER (IF OTHER THAN INSURED)	2. _____
☐ MR. ☐ MRS. ☐ MISS _____ (FIRST / MIDDLE / LAST)	3. _____

In Accordance with the Beneficiary Provisions of the Policy, I hereby request Combined Insurance Company of America to pay the death benefit of the Insurance Policy above to the Named Beneficiary indicated below.

Beneficiary Designation: Primary beneficiaries are those individuals that receive the insurance proceeds for the coverage indicated above upon your death. Primary beneficiaries share the proceeds equally unless otherwise indicated. Contingent beneficiaries will only receive payment if none of the primary beneficiaries survive you.

PRIMARY BENEFICIARY NAME(S)	RELATION TO INSURED:
1. ☐ MR. ☐ MRS. ☐ MISS _____ (FIRST / MIDDLE / LAST)	_____
2. ☐ MR. ☐ MRS. ☐ MISS _____ (FIRST / MIDDLE / LAST)	_____
CONTINGENT BENEFICIARY NAME(S)	**RELATION TO INSURED:**
1. ☐ MR. ☐ MRS. ☐ MISS _____ (FIRST / MIDDLE / LAST)	_____
2. ☐ MR. ☐ MRS. ☐ MISS _____ (FIRST / MIDDLE / LAST)	_____

Dated at _____ (City, State) this _____ (Date) day of _____ (Month, Year)

X _____
Signature of Witness

Address of Witness _____

City _____ State ____ Zip _____

X _____
Signature of Policyowner

X _____
Signature of Spouse *(Required in the following states: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, and Wisconsin.)*

HOME OFFICE USE ONLY Received by Worksite Solutions _____ (DATE) _____ (INITIAL)

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COMBINED INSURANCE