



## POLICY SERVICE REQUEST FORM

Policy Number \_\_\_\_\_

### INSURED'S INFORMATION

|                      |             |           |
|----------------------|-------------|-----------|
| Name _____           |             |           |
| Street Address _____ |             |           |
| City _____           | State _____ | Zip _____ |
| DOB _____            | SSN _____   |           |
| Phone Number _____   |             |           |
| Email _____          |             |           |

### OWNER'S INFORMATION (if different)

|                      |             |           |
|----------------------|-------------|-----------|
| Name _____           |             |           |
| Street Address _____ |             |           |
| City _____           | State _____ | Zip _____ |
| DOB _____            | SSN _____   |           |
| Phone Number _____   |             |           |
| Email _____          |             |           |

|                                                                                                           |
|-----------------------------------------------------------------------------------------------------------|
| 1. Change Name to _____<br>Reason for Change _____<br>(include legal documentation confirming change)     |
| 2. Request for Information:<br><input type="checkbox"/> Illustration <input type="checkbox"/> Other _____ |

|                                                                                                                                                                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 3. Change Billing Mode to:<br><input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual<br>Billing Address _____ |
| 4. Reduce Disability Income Policy<br>Monthly Benefit to _____<br>Remove Rider _____<br>Increase Elimination Period to _____                                                                    |
| 5. Decrease Life Policy (WL not applicable)<br>Face amount to \$ _____                                                                                                                          |
| 6. Cancel Benefit/Rider on Life Policy<br>Name of Rider _____                                                                                                                                   |
| 7. Option Change for UL<br>Level _____<br>Increasing _____                                                                                                                                      |
| 8. Terminate Policy <input type="checkbox"/> Surrender <input type="checkbox"/> Cancel                                                                                                          |
| 9. Special Requests _____<br>_____<br>_____<br>_____<br>_____<br>_____                                                                                                                          |

The provisions below are a part of this form, and I (we) acknowledge that I (we) have read and understand those which are relevant to the request being made.

\_\_\_\_\_  
Policyowner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Assignee or other required signature

\_\_\_\_\_  
Date

### (For Home Office use only) ACKNOWLEDGEMENT

The company has processed the change(s) requested and has filed the request form.  
Illinois Mutual Life Insurance Company

Dated: \_\_\_\_\_

By: \_\_\_\_\_  
Authorized Person

## AGREEMENT

1. This combination Policy Service Request is provided for the convenience of policyowners and agents. If a request cannot be honored without additional information or forms, those will be provided by Illinois Mutual (the Company).
2. For a request for **cash surrender**, the owner warrants that no insolvency or bankruptcy proceedings are pending. The date upon which the Company receives the form at its Home Office is the date upon which the net surrender cash value is determined and the date upon which the death benefit and other provisions of the policy terminate.
3. Any request for **cancellation of riders or reductions in face amount** will be effective when this form is received by the Company at its Home Office. **Any addition of riders or increases in face amounts** are subject to satisfactory evidence of insurability and approval by the Company.
4. The owner agrees that the Company may waive any provision requiring that the **policy be presented for change** and that the Company may require presentation of the policy for certain changes.

Policyowner is to attach this approved copy of this form to the policy.