

# 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.

<b>FULL NAME OF INSURED</b> <input type="checkbox"/> MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MISS _____ <div style="display: flex; justify-content: space-between; width: 100%;"> <span>FIRST</span> <span>MIDDLE</span> <span>LAST</span> </div>	<b>POLICY NUMBER(S):</b> 1. _____ 2. _____ 3. _____
<b>OWNER (IF OTHER THAN INSURED)</b> <input type="checkbox"/> MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MISS _____ <div style="display: flex; justify-content: space-between; width: 100%;"> <span>FIRST</span> <span>MIDDLE</span> <span>LAST</span> </div>	

**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.

<b>PRIMARY BENEFICIARY NAME(S)</b> 1. <input type="checkbox"/> MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MISS _____ <div style="display: flex; justify-content: space-between; width: 100%;"> <span>FIRST</span> <span>MIDDLE</span> <span>LAST</span> </div> 2. <input type="checkbox"/> MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MISS _____ <div style="display: flex; justify-content: space-between; width: 100%;"> <span>FIRST</span> <span>MIDDLE</span> <span>LAST</span> </div>	<b>RELATION TO INSURED:</b> _____ _____
<b>CONTINGENT BENEFICIARY NAME(S)</b> 1. <input type="checkbox"/> MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MISS _____ <div style="display: flex; justify-content: space-between; width: 100%;"> <span>FIRST</span> <span>MIDDLE</span> <span>LAST</span> </div> 2. <input type="checkbox"/> MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MISS _____ <div style="display: flex; justify-content: space-between; width: 100%;"> <span>FIRST</span> <span>MIDDLE</span> <span>LAST</span> </div>	<b>RELATION TO INSURED:</b> _____ _____

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

**X** \_\_\_\_\_ **X** \_\_\_\_\_  
Signature of Witness Signature of Policyowner

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

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

<b>HOME OFFICE USE ONLY</b>	Received by Worksite Solutions _____ <small>(DATE) (INITIAL)</small>
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