All American Associates

POLICY CHANGE REQUEST FORM

Loyal American Life Insurance Company

This form is to be completed and signed by the employee (insured) when any type of change pertaining to the cancer policy is requested.

NAME: ______________________________

ADDRESS: ______________________________

EMPLOYER: ______________________________

POLICY NUMBER:______________________ **GROUP NUMBER:** ____________________

Type of change requested:

( ) Change name to: ____________________ from:____________________

Reason: ______________________________

( ) Increase premium from individual rate of $ ____________ to family rate of $____________
Effective:______________________ (**Complete a new application**).

( ) Add Intensive Care rider - Premium: $ ______________ □ $300/day □ $600/day Effective: ____________
(**Complete a new application**).

( ) Add Radiation/Chemotherapy rider: - Premium: $ ________ □ $10,000 □ $15,000 Effective:____________
(**Complete a new application**).

( ) Cancel Intensive Care rider: effective ______________________________

( ) Cancel Radiation/ Chemotherapy rider: effective ______________________________

( ) Decrease premium from Family rate of $ ____________ to individual rate of $____________
Effective: ____________

( ) Cancel my Cancer program effective: ______________________________

( ) Direct billing for premium payment at the above address for a
______ monthly PAC (automatic payment plan)______quarterly ______ semi-annual _____annual premium

( ) Insured deceased ...... contact spouse for substitution and delete from future billings.

( ) Other ______________________________

____________________ **Date**

____________________ **Policyholders Signature**

Return the completed form to your Payroll Deduction center to forward to the Administrative Offices for change.

All American Associates
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Topeka, Kansas 66614
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