Philadelphia American Life Insurance Company

P. O. Box 4884
Houston, TX 77210

POLICY CHANGE REQUEST FORM

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 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 All American for change. If Payroll Center has already been notified, please send directly to All American Marketing at 2942 SW Wanamaker Dr. Ste. 150 Topeka, KS 66614 or Fax (785) 228-1720.