U.S. FINANCIAL LIFE Insurance Co.

USFL
PO Box 3016
Monroe, WI 53566-3016
Phone: 800-959-3894
Fax: 855-784-1586

REQUEST FOR POLICY CHANGE

POLICY NUMBER: _____
POLICY OWNER'S NAME: _____
POLICY OWNER'S ADDRESS: _____
POLICY OWNER'S DATE OF BIRTH: _____
POLICY OWNER'S EMAIL ADDRESS: _____
POLICY OWNER'S TAXPAYER ID: _____
POLICY OWNER'S PHONE NUMBER: _____
POLICY OWNER'S NAME: _____
POLICY OWNER'S ADDRESS: _____
POLICY OWNER'S DATE OF BIRTH: _____
POLICY OWNER'S EMAIL ADDRESS: _____
POLICY OWNER'S TAXPAYER ID: _____
POLICY OWNER'S PHONE NUMBER: _____

AGENT'S NAME: _____
INSURED'S NAME: _____
INSURED'S ADDRESS: _____
INSURED'S DATE OF BIRTH: _____
INSURED'S EMAIL ADDRESS: _____
INSURED'S TAXPAYER ID: _____
INSURED'S PHONE NUMBER: _____
POLICY OWNER'S NAME: _____
POLICY OWNER'S ADDRESS: _____
POLICY OWNER'S DATE OF BIRTH: _____
POLICY OWNER'S EMAIL ADDRESS: _____
POLICY OWNER'S TAXPAYER ID: _____
POLICY OWNER'S PHONE NUMBER: _____

SELECT THE DESIRED POLICY CHANGE TRANSACTION BELOW:

In order to prevent delay in processing, please complete all requested information in their entirety,
including all doctor(s) information, complete address(es) and phone number(s).
Reinstatement forms can be found at https://www.heritageli.com/usfli

☐ 1. Change policy stated amount from _____ to _____.
(A completed reinstatement form is required for increase request.)

☐ 2. Cancel Rider/Benefit: ☐ Child ☐ Additional Insured Person ☐ Waiver ☐ Accidental Death

☐ 3. Change Death Benefit Option to: ☐ Option A ☐ Option B

☐ 4. Term Re-Entry. *(A completed reinstatement form is required for Term Re-Entry requests.)*

The current beneficiary on your existing term policy will be transferred to your new beneficiary, if approved. Please provide the following information on the current beneficiary listed:

Beneficiary Name/Entity Name _____

Residential Address or place of business

_____

SSN#/EIN#/TIN# _____ Date of Birth _____ Telephone Number _____

Email Address _____ Relationship to Insured _____

Percentage (%) of Benefits _____ Type of Beneficiary (Primary or Contingent) _____

THE FOLLOWING ARE ALLOWED FOR RIGHT LIFE AND TERM POLICIES ONLY

☐ 5. Remove or reduce policy rating.

(A completed reinstatement form is required for rate or smoker class changes. For smoker class changes, please include a completed tobacco questionnaire that is available on our website https://www.heritageli.com/usfli

NOTICE – Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. The above statements are complete and true to the best of my/our knowledge and belief.

Dated:_____ at _____
City State

_____ _____
Signature of Insured Signature of Policy Owner if other than Insured

_____ _____
Signature of Title of Assignee Signature of Policy Owner

_____ _____
Signature of Witness Signature of Policy Owner