Administrative Address
PO Box 17628, Winston-Salem, NC 27116
Toll-Free: (833) 658-2844
Fax: (336) 464-2664
Email: lbigcustomerservice@actmanre.com

Liberty Bankers®
Insurance Group | *Liberty Bankers Life*

Policyholder Service Request Form: Supplemental Health

POLICYHOLDER NAME:	POLICY NUMBER:

Change of Address

NEW MAILING ADDRESS:

CITY:	STATE:	ZIP:

Change of Name

(For name changes due to marriage, provide a copy of government issued ID with new name or marriage certificate. For all other changes, provide a copy of court decree.)

FROM:

TO:

Change of Beneficiary

NAME OF NEW BENEFICIARY	DOB	SSN	PRIMARY OR CONTINGENT	PERCENTAGE *(Total for all beneficiaries combined must equal 100%)*
1.				
2.				
3.				

Premium Billing Change

☐ BANK DRAFT (M, SA, A) ☐ CREDIT CARD (M) ☐ LISTBILL (M) ☐ DIRECT BILL (SA, A)

PREMIUM MODE: ☐ MONTHLY (M) ☐ SEMI-ANNUALLY (SA) ☐ ANNUALLY (A)

Bank Draft Information

BANK NAME:

ROUTING #:	ACCOUNT #:

Debit/Credit Card Information

DEBIT/CREDIT CARD #:	EXP. DATE:

NAME AS IT APPEARS ON CARD:

Card Billing Address

CITY:	STATE:	ZIP:

TELEPHONE NUMBER:

Bank Draft, Credit/Debit Card Authorization

I authorize Liberty Bankers Life Insurance Company to withdraw funds from my account or charge my debit/credit card for my renewal premiums at the frequency indicated by the premium mode selected above. I further authorize my financial institution to pay any preauthorized electronic fund transfers from my account or charge my debit/credit card to Liberty Bankers Life Insurance Company. I understand this authorization will be in effect until I give written notice, at least five business days in advance of a scheduled withdrawal, of my intent to cancel electronic bank draft or debit/credit card payments.

Policyholder Service Request Form: Supplemental Health

☐ **Duplicate Policy Request**

☐ **Cancellation Request**

☐ **Nicotine user to Non-nicotine user (Complete attached questionnaire)**

☐ **Adding dependents (including newborns and adopted)**

NAME OF DEPENDENT	SEX (M/F)	DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NUMBER	DEPENDENT (NEWBORN OR ADOPTED)
1.				
2.				
3.				

☐ **Continuing Coverage for Dependent over Age 26 (with disability)**

Complete attached questionnaire.

☐ **Conversion (due to Dissolution of Marriage, Domestic Partnership, or Civil Union)**

Complete new application for spouse to convert to a new policy.

☐ **Decreasing Benefits or Removing Riders**

Note: Increasing or adding requires a new application submitted for underwriting review.

Decreasing Benefits on Base Plans

BASE PLAN	CURRENT BENEFIT AMOUNT	NEW BENEFIT AMOUNT REQUESTED
☐ Hospital Indemnity Base Plan		
☐ Accident Base Plan		
☐ Cancer Base Plan		
☐ Heart and Stroke Base Plan		
☐ Critical Care Base Plan		

Removing Riders

- ☐ Hospital Indemnity Rider
- ☐ Accident Rider
- ☐ Cancer Rider
- ☐ Heart and Stroke Rider
- ☐ Critical Care Rider
- ☐ Ambulance Services Rider
- ☐ Emergency Room/Urgent Care Rider
- ☐ Outpatient Therapy and Medical Devices Rider
- ☐ Dental, Vision, and Hearing Rider
- ☐ Skilled Nursing Facility/Hospice Care Rider
- ☐ Skilled Nursing Facility with Elimination Period/Hospice Care Rider
- ☐ Lump Sum Hospital Confinement Rider
- ☐ Outpatient Surgery Rider
- ☐ Outpatient Diagnostic Services and Wellness Rider
- ☐ Return of Premium Upon Death Rider
- ☐ Accident Income Recovery Rider
- ☐ Hospital Indemnity Automatic Increase Rider

Insured Printed Name: _____ Date: _____

Signature: _____