

# Colonial Life & Accident Insurance Company

**REQUEST FOR SERVICE: What type of service are you requesting? Please check only the boxes that apply.**

**1 GENERAL INFORMATION**

Insured's name as currently listed on the policy:	Social Security Number (SSN):	Date of Birth(mm/dd/yyyy):
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List all policy numbers related to this request (required to process):

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Employer Name:

**2 NAME CHANGE** Please attach a copy of legal evidence.

Previous Name:	Current Name:	Reason: <input type="checkbox"/> Correction <input type="checkbox"/> Marriage/Divorce <input type="checkbox"/> Other
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**3 ADDRESS CHANGE**

Address:	Apt. #:	City:	State:	ZIP:
Telephone: (     )	Mobile: (     )	Email:		

**4 REQUEST FOR CHANGE OF BENEFICIARY FORM**

Please visit us at our website, coloniallife.com, or contact us at 1.800.325.4368 to request a copy of the Change of Beneficiary form.

**5 PREMIUM PAYMENT METHOD CHANGE** Please select one of three easy payment methods.

<input type="checkbox"/> <b>1. Please deduct monthly premiums from my banking account.</b> RANGE: A). 1st-5th B). 6th-10th C). 11th-15th D). 16th-20th E). 21st-26th. Your draft will occur on one of the dates within the range you have selected.  <i>Please attach a voided check, and circle one range of days you would like your checking account to be drafted.</i>  Signature of checking account owner: _____	<b>OR</b>	<input type="checkbox"/> <b>2. Please bill me directly.</b> Choose one of the following: <input type="checkbox"/> <b>Quarterly</b> (Submit a payment 3 times your monthly premium.) <input type="checkbox"/> <b>Semi-annually</b> (Submit a payment 6 times your monthly premium.) <input type="checkbox"/> <b>Annually</b> (Submit a payment 12 times your monthly premium.)	<b>OR</b>	<input type="checkbox"/> <b>3. Change to Payroll Deductions.</b>  Employer Name: _____  Billing Control Number or Account Number: _____  <i>Please contact your Plan Administrator to start payroll deduction.</i>
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**6 CANCELLATION, SURRENDER OR POLICY CHANGE** You must also complete **Sections 9 and 12** on the reverse side.

**Cancel/surrender the policy/policies** (This option will cancel or cash surrender your policy/policies.)

**Cancel the following riders on the policy/policies:**  Spouse Rider  Dependent Rider (This will cancel coverage for ALL dependents.)  
 (This option will cancel policy riders only.)  Other (name rider) \_\_\_\_\_

<input type="checkbox"/> Change Two-Parent to Individual	<input type="checkbox"/> Change Two-Parent to One-Parent	<input type="checkbox"/> Change One-Parent to Individual
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Please provide name, birthdate, and social security number for spouse/dependent(s) continuation:	Name:	Date of Birth:	SSN:
	Name:	Date of Birth:	SSN:

**7 POLICY LOAN** You must complete **Sections 9 and 12** on the reverse side. Select either Section 7 or 8 per policy number, **not both**.

<b>Please select ONE option per policy number.</b>	<input type="checkbox"/> I am requesting a policy loan for the following amount: \$ _____ <input type="checkbox"/> I am requesting a policy loan for the maximum amount available.	◀ If the amount requested is more than the available cash value, we will process this request for the maximum amount available.
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**Check this box also if you are requesting information regarding repayment of your loan on your Universal Life policy.**

**By signing on the reverse side, I hereby assign the policy to the insurer as collateral.**

*Policy loans are available on select life policies only. Minimum loan amounts may apply as stated in your policy contract. You will receive annual loan and interest notices until the loan is fully repaid. For information regarding repayment of your loan, please contact us at 1.800.325.4368.*

**Continued on Reverse Side ➡**

**8 WITHDRAWAL/PARTIAL SURRENDER** (Universal Life Policy) Complete **Sections 9 & 12**. Select either Section **7 or 8** per policy number, **not both**.

<b>Please select ONE option per policy number.</b>	<input type="checkbox"/> I am requesting a policy withdrawal/partial surrender for the following amount: \$ _____	◀ If the amount requested is more than the available cash value, we will process this request for the maximum amount available.
	<input type="checkbox"/> I am requesting a policy withdrawal/partial surrender for the maximum amount available.	

Only one policy withdrawal/partial surrender is allowed per policy year. Minimum withdrawal amounts apply as stated in your policy contract. There will be a processing fee as stated in your policy contract. Policy withdrawals/partial surrenders are available on universal life policies only. If your policy is not a universal life policy and you request a withdrawal, we will process the request as a policy loan.

**9 TAX WITHHOLDING OPTIONS** Please read and complete this section if you are requesting a surrender or withdrawal.

Election of a tax withholding option is not available for tax-qualified products. The insurer is required to withhold 20% of any recognized gain for tax-qualified products unless proceeds are rolled directly into an IRA or other qualified retirement plan.

Under certain criteria established by the Treasury Department, a gain may be reportable by the insurer at the time of surrender, partial surrender or withdrawal of this policy, creating a taxable situation. However, any gain is taxable income for the current tax year.

If a gain is reportable, an IRS Form 1099R will be sent to you at the beginning of the next calendar year reporting the recognized gain, and a copy of Form 1099R will be sent to the IRS. If a gain is not reportable when the surrender, partial surrender or withdrawal is processed, an IRS Form 1099R will not be sent. In addition, if a gain is reportable, the insurer is required to withhold 10% of any recognized gain, unless the policy owner elects not to have the tax withheld. You may be subject to penalties under the estimated tax payment rules if you elect not to have tax withheld and payments of estimated tax and other withholding are not adequate to satisfy tax liability.

**Choose one of the following options. If an option is not selected, a withholding will automatically be made.**

- I **DO NOT** want to have Federal Income Tax withheld in conjunction with this surrender/partial surrender/withdrawal.
- I **DO** want to have Federal Income Tax withheld from the surrender/partial surrender/withdrawal proceeds.

**10 SPECIAL NOTICE FOR RESIDENTS OF A COMMUNITY PROPERTY STATE**

A spouse or former spouse may have an interest in life insurance proceeds or any accumulated cash value if the policy premiums were paid with community funds. It is your responsibility to consult your legal advisor to 1) ensure that any required consent from a spouse or former spouse has been received and 2) ensure that your spouse or former spouse will not be able to make a claim against any policy values and/or the proceeds in the event any policy benefits become payable.

**11 OTHER REQUESTS OR REMARKS** Includes illustration changes, policy face value decrease, age discrepancies, or premium increase, etc.

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**12 SIGNATURES REQUIRED** You must fill out this section **COMPLETELY** in order for us to process your request.

➔ **BE SURE TO LIST A SOCIAL SECURITY NUMBER AND DATE OF BIRTH BELOW. FAILURE TO PROVIDE THIS INFORMATION MAY DELAY PROCESSING.**

I have carefully read this request and agree that it is properly and fully completed. I understand that this request is subject to the provisions and conditions of the policy and that the company may require additional information or requirements. I certify that the policy is not pledged or assigned to any other person or corporation, except where stated in the request, and that no proceedings or bankruptcy or insolvency have been filed or are now pending.

*I certify the **Social Security Number** and **Date of Birth** indicated are correct, and I hereby authorize Colonial Life to execute this request.*

Print Policy Owner's Name: \_\_\_\_\_ Policy Owner's Social Security Number: \_\_\_\_\_

Policy Owner's address: \_\_\_\_\_ **AND** Policy Owner's Date of Birth: \_\_\_\_\_

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Policy Owner's Email Address: \_\_\_\_\_ Daytime Telephone: \_\_\_\_\_

**Policy Owner's Signature:** \_\_\_\_\_ **Date:** (MM/DD/YYYY) \_\_\_\_\_

Assignee's signature (if any): \_\_\_\_\_ Date: (MM/DD/YYYY) \_\_\_\_\_

**MAIL TO: Colonial Life & Accident Insurance Company, P.O. Box 1365, Columbia, SC 29202-1365**  
**Phone: 1.800.325.4368 / To fax requests: 1.800.561.3082 coloniallife.com**