NEW ERA Life Insurance Companies

P.O. Box 4484 • Houston, TX 77079-4884
800-552-7879 Fax: 281-368-7148

REQUEST FOR POLICY SERVICE – HEALTH

PLEASE TYPE OR PRINT

POLICY NUMBER	NAME OF INSURED	NAME OF OWNER(if other than Insured)

PLEASE MAKE THE FOLLOWING MARKED CHANGE(S) ON THE POLICY IDENTIFIED ABOVE

☐ **Change name of :** ☐ Insured ☐ Owner ☐ Payor ☐ Beneficiary

From:_____To:_____
Full Name

Reason for change: _____
(Marriage, Court Decree, Etc)

Please send a copy of Driver's License, Marriage License, Court Order, etc. along with this request to the address above.

☐ **Change Address of :** ☐ Insured ☐ Owner ☐ Payor ☐ Beneficiary

_____ _____
Number and Street Phone Number

_____
City State Zip Code

☐ **Duplicate Policy:**
I certify that the policy identified above has been lost or destroyed and I have no knowledge of its whereabouts. I hereby request issuance of a duplicate of said policy, or certificate of insurance should duplicate policy forms not be available. I hereby agree that any certificate or duplicate policy issued shall create no liability on the part of the Company other than that set out in the original policy. If at any time the original policy is found, such certificate or duplicate policy will be null and void and immediately returned to the Company. Please enclose payment of a $25 administration fee for a duplicate policy.

☐ **Cancellation:**
Please cancel the policy listed above.
Requested effective date of cancellation: _____
Reason for cancellation: _____
(If deceased, please include a photocopy of death certificate.)

☐ **Additional Requests:**

_____

_____

_____

_____

I agree that my signature below shall apply to each request which has been checked on this form.

_____ _____
Date Signature of Owner

FOR NEW ERA LIFE INSURANCE COMPANY USE ONLY

ACKNOWLEDGEMENT OF REQUEST FOR CHANGE – PLEASE ATTACH TO POLICY

NEW ERA LIFE INSURANCE COMPANY HAS RECEIVED THE CHANGE REQUEST AND MADE IT PART OF OUR RECORDS.

DATED AT HOUSTON, TX _____ BY _____