CONTRACT ADMINISTRATION CHANGE FORM **POLICY # ________________**

POLICY OWNER

FIRST NAME MIDDLE NAME

LAST NAME

	CHANGE YES	CHANGE NO	
PREMIUM PAYMENT	☐	☐	Change Mode of Payment to: Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual ☐ Change Form of Payment to: Cash ☐ Post-Dated Checks ☐ Salary Deduction ☐ With effect from: ________________ New Premium $ ________________
NON-FORFEITURE OPTION	☐	☐	☐ Surrender/Cancellation ☐ Reduced Paid-Up Insurance ☐ Maturity ☐ Extended Term Insurance
SUPPLEMENTAL BENEFITS/RIDERS	☐	☐	ADD DELETE ADD DELETE ☐ ☐ Waiver of Premium ☐ ☐ Payor's Disability Waiver ☐ ☐ Accidental Death ☐ ☐ Payor's Death Waiver ☐ ☐ Accidental Death & Dismem. ☐ ☐ Income Disability Occupation: ________________ Exact Duties: ________________ Effective Date: ________________ New Premium $ ________________
AMOUNT OF INSURANCE	☐	☐	INCREASE ☐ DECREASE ☐ From $ ________________ To $ ________________ Effective Date: ________________ New Premium $ ________________ (Evidence of insurability is required if amount of insurance is to be increased)
DUPLICATE CONTRACT (LOST POLICY)	☐	☐	Provide details as to the Lost/Destruction of the Original Policy ________________ ________________
OTHER	☐	☐	Specify Request ________________ ________________

Are you a resident of Belize? Yes ☐ No ☐ Are you a citizen of Belize? Yes☐ No☐

Are you a citizen of any other country other than Belize? Yes☐ No☐ If yes, please state which country: ________________

Dated at: ________________ this ______ day of ____________ in the year ________________

Policy Owner's Signature ________________ Witness: ________________

Agent's Name & No. ________________

Note:

1. Proof of Identification is required for any change
2. The Policy Document is to be submitted for endorsement(s) to be made
3. For a Duplicate Contract request, evidence as to the lost or destruction of the original policy is required