5STAR LIFE INSURANCE COMPANY
Administrative Offices: P.O. Box 83043, Lincoln, NE 68501-3043 • 866-863-9753

REQUEST FOR CHANGE FORM

I request the below listed changes to be applied to the following policies that I own:
(please place a check mark next to the policies to be affected).

✓	Policy #	Insured	Owner

Please place a check mark next to the changes being made.

[ ] 1. REQUEST TO CANCEL COVERAGE

I _____, owner of the above policy(s) would like to cancel the policy which I have marked.

[ ] 2. CHANGE OF BENEFICIARY

I hereby revoke any previous designation of beneficiaries and request that the life insurance benefit payable at my death be paid in accordance with the designation below. If more than one beneficiary is designated in the same beneficiary class, payment shall be made in equal shares to the designated beneficiaries of the class who survive me.

Primary Beneficiary Relationship Date of Birth SSN
Name _____ _____ _____ _____

Address _____

Name _____ _____ _____ _____

Address _____

Contingent Beneficiary
Name _____ _____ _____ _____

Address _____

[ ] 3. CHANGE OF NAME

I elect to change the name of the [ ] Insured [ ] Owner [ ] Payor to the following:
Please provide a legal document for any name change.

Name before change _____

Name after change _____

Date of Change _____

Reason for change [ ] Marriage [ ] Divorce [ ] Adoption [ ] Other:_____

Policy#'s

[ ] 4. CHANGE OF ADDRESS [ ] Insured [ ] Owner [ ] Payor

New Address_____

New Phone Number _____

[ ] 5. OWNERSHIP CHANGE

I elect to change the owner of this policy to the following individual and understand that all benefits, rights and privileges incident to ownership of this policy will be vested in the new owner.

New Owner _____ SSN# _____

Address of new Owner _____

Signature of new owner _____Relationship _____

Please Note: The CURRENT owner MUST sign below to request this ownership change.

[ ] 6. CHANGE OF PAYOR (This person will receive all bills for coverage)

New Payor _____

Address _____

[ ] 7. REQUEST FOR DUPLICATE / LOST POLICY

Reason for request [ ] Cannot locate [ ] Never received [ ] Other _____

[ ] 8. DECREASE IN COVERAGE

Policy # _____ (If coverage is to be increased, a new application is required.)

Benefit Amount from $ _____ to $ _____

Decrease Coverage for ☐ Spouse ☐ Child ☐ Other _____

Specific Details/Instructions _____

_____

_____

[ ] 9. OTHER

_____

_____

SIGNATURES

Date _____

Signature of Owner _____

Signature of Insured_____

Owner's Mailing Address _____

For Company Use Only

The change(s) above have been acknowledged, accepted and recorded by the Company

Date _____ By _____