INDIVIDUAL ASSURANCE COMPANY, LIFE, HEALTH & ACCIDENT

930 E. 2nd Street, Suite 100 Edmond, OK 73034 ♦ 1-800-821-5434

REQUEST FOR SERVICE

Email completed form to PolicyOwnerService@iaclife.com, fax to (405) 285-0836, or mail to PO Box 30685, Edmond, OK 73003

POLICY NUMBER	INSURED	OWNER (If other than insured)

CHANGE NAME OF:

☐ Insured ☐ Owner ☐ Payer

FORMER NAME (please print)	NEW NAME (please print)

REASON FOR CHANGE (If other than correction, marriage or divorce, please attach copy of legal evidence; if available.)

☐ DUPLICATE POLICY REQUEST
I hereby declare the original policy has been lost or destroyed. Please issue a duplicate policy if possible or a certificate of insurance. If original policy is located, I promise to return the duplicate to the Company.

☐ FULL SURRENDER
I request payment of the net cash value in exchange for surrender of this policy. No bankruptcy proceedings are outstanding against me and no liens are pending against the policy except as follows:

☐ CHANGE OF ADDRESS (Indicate new address)

☐ REDUCE COVERAGE ON POLICY/REDUCE PREMIUM
I hereby request to reduce my policy face amount to

$____________________ , or

I hereby request to reduce my policy premium to

$____________________

Payroll Period:_____________ Effective:_____________

☐ CHANGE OF TELEPHONE NUMBER
(indicate new telephone number)

☐ CANCELLATION OF RIDERS
I hereby request cancellation of the following riders to my policy effective __________________________ .

- ☐ Waiver of Premium
- ☐ Accidental Death Benefit
- ☐ Guaranteed Insurability Option
- ☐ Waiver of Monthly Deduction
- ☐ Other Insured
- ☐ Children's Term
- ☐ Cost of Living
- ☐ Disability Income Plan

☐ CHANGE OF PAYMENT MODE/AMOUNT

	New Payment Amount
☐ Check-O-Matic Monthly	$ ________________
☐ Direct Bill Monthly	$ ________________
☐ Direct Bill Quarterly	$ ________________
☐ Direct Bill Semi-Annually	$ ________________
☐ Direct Bill Annually	$ ________________
☐ List Bill Biweekly	$ ________________
☐ List Bill Semi-Monthly	$ ________________

COMPLETE FOR ABOVE REQUEST

By signing below, I declare that the information provided herein is true, complete, and correct. I direct that any amendment of the policy requested above take effect on the date this request is signed, but without any liability to the Company on account of payment made or action taken by it before this request was acknowledged by the Company. I agree that the Company may waive any policy provision requiring presentation of the policy for endorsement, but it may require such presentation if desired.

____ ____________________

Signature of Owner Date

The undersigned agrees to the above requests and changes.

__________________________ __________________________ __________________________

Signature of Owner's Spouse (If resident of community property state.) | Signature of Assignee (If any.) | Signature of Irrevocable Beneficiary (If any.)