

Section 6: Change In Benefit Or 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: _____

Section 7: Other

Date: _____ Signature of Witness: _____

Signature of Insured: _____ Required Signature of Owner: _____ Required if other than primary Insured

Owner's Mailing Address: _____
Street Address City State Zip Code