Professional Insurance Company In California, PIC Life Insurance Company

Mailing Address: PO Box 80637, Lincoln, NE 68501-0637 • 800-289-1122

POLICYHOLDER'S REQUEST FOR CHANGE

Policy No.(s)			N	9400014		
☐ Section 1: Change of Beneficiary						
Name and Address of Primary Beneficiary	Relationship	Date of Birth	Social Security #	Settlement Request, If Any (Use percentage only. Do not use dollar amounts.		
Name and Address of Contingent Beneficiary	Relationship	Date of Birth	Social Security #	Settlement Request, If Any		
Name and Address of Contingent Schoolsta.	Troise to the second	5400	boom cooning.	(Use percentage only. Do not use dollar amounts.		
The insured reserves the right to further change the benefician	y without the consent	of the beneficiary.				
☐ Section 2: Change of Name		llen en e				
From:Lest First Middle	To: _	Lest	First	Middle		
By Reason of: ☐ Correction ☐ Marriage ☐ Court Ord						
·						
Prior Signature:			(*Copy of legal documer	it required)		
☐ Section 3: Request for Certificate of Lost	Policy or Dupli	cate Policy				
☐ Request for Certificate of Lost Policy (No Charge) (Policy over 5 years in age)						
Request for Duplicate Policy (\$15 Charge)	☐ Cannot Locate Original Policy☐ Never Received Original Policy					
(Policy under 5 years in age)	☐ Other					
☐ Section 4: Accident and Health Cancellat	ion of Coverage	Only				
	tek ang jabur di katalon ing katalon katalon at katalon katalon katalon katalon katalon ing terbasar katalon i Tanggar katalon ing terbasar katalon ing terbasar katalon ing terbasar katalon ing terbasar katalon ing terbas	ikka tradi a sebagain na 1904 iki ka ta Tara ka 1965 a kai terin peron a reke 1972 iki nasari sa 1965.		adder der Millereiche Geseller Addiesenstelleren zu der eutwichten der eine der eine der eine der eine der ein I		
	own	er of the above poil	cy(ies), would like to	cancel.		
☐ Section 5: Ownership Change						
Change Owner From:	\$\$:J.71-					
Last First	Middle		* ! O #L			
To:Last First	Middle	ა	cial Security #:	Application of the Control of the Co		
Address:Street Address	***************************************	City	State	Zip Code		
Signature of New Owner:						

continued on reverse side

☐ Section 6: Change In Benefit Or Coverage					
Policy #:	_(If coverage is to be inc	reased, a new application is required.)			
Benefit Amount from \$:	to	\$:			
Decrease Coverage for:	☐ Child ☐ Other				
Specific Details/Instructions:					
☐ Section 7: Other					
Date: Signature	e of Witness:				
Signature of Insured:	Required	Signature of Owner:	Required if other than primary Insured		
Owner's Mailing Address:		City	State Zip Code		