INSTRUCTIONS FOR HEALTH POLICY INFORMATION FORM

- Please read these instructions carefully before completing this form.
- ***COMPLETE SECTIONS A FOR ALL REQUESTS*** to ensure we have the most updated information on file.
- If documentation is required to make the requested change, please include with your returned form.
- Return completed form to address or fax number provided in the Checklist section.
- ***Section F MUST*** be signed by the policyowner for requests to be valid.

A OWNER/INSURED INFORMATION

PLEASE ALWAYS COMPLETE SECTION A to ensure the most up to date information is on file. If the current owner/insured is deceased, please contact customer service. For any changes/corrections to vital information (DOB, SSN or Name) please attach a copy of the valid documentation to verify information. This can include a copy of your Social Security Card, Drivers License, Birth Certificate or Passport.

B BENEFICIARY INFORMATION

PLEASE COMPLETE SECTION B to confirm or change the beneficiary disignations for your policy. **Please be aware that on some health products beneficiary information does not appy to the policy.**

The information provided in this section instructs us how to distribute any payable proceeds of the policy upon the Insured's death. Please complete this section to confirm that our records contain the most current information.

Owner(s) and irrevocable beneficiaries (if applicable) must sign in Section F. If multiple beneficiaries are named, the percentage of proceeds must total 100%. If percentages are not provided, proceeds will be divided equally among beneficiaries.

Each beneficiary will be considered a Primary Beneficiary with equal distribution unless otherwise specifically designated.

If designating an irrevocable beneficiary, please write “irrevocable” next to each applicable beneficiary you wish to make irrevocable. An irrevocable beneficiary designation can only be changed by the policyowner with the irrevocable beneficiary’s consent.

If you plan to designate more than four beneficiaries, please provide additional beneficiary information on a separate sheet and include with your completed form.

C PAYOR INFORMATION

Complete Section C if you would like to change the Payor of the policy. **If this section is not completed, no changes will be made to the Payor information.** If changes are necessary to automatic bank draft information, please contact our office at 800-523-9100 to obtain a change form. If changes are made to the Payor information, the current Owner must sign in Section F.

D LEGAL NAME CHANGE

Complete Section D if there has been a change to legal name. Former full name must be printed and former signature must be signed. New name must be printed and new signature must be signed. Current owner must sign in Section F. ***Do not use this section to change the owner of this policy.***

Indicate the reason for change and attach required documentation:

- **marriage/divorce** - please include a copy of marriage certificate or divorce decree with form
- **trust documentation** - please include a copy of the trust amendment documentation
- **court order** - please include a copy of court order with form

E RELEASE OF INTEREST IN COMMUNITY PROPERTY STATES OR TERRITORY

Complete Section E if you currently reside in a community property state or territory **(Arizona, California, Idaho, Louisiana, New Mexico, Nevada, Texas, Washington, Wisconsin or Puerto Rico).** If you do not live in a community property state or territory, do not complete this section.

F AUTHORIZATIONS/SIGNATURES

SECTION F MUST BE SIGNED BY THE POLICYOWNER or no changes will be made. When the policy is community property, the current owner's spouse also must sign the form in Section E, if you currently reside in a community property state or territory (**Arizona, California, Idaho, Louisiana, New Mexico, Nevada, Texas, Washington, Wisconsin or Puerto Rico).**

- **TRUST OWNED -** The trustee(s) must sign, including his/her title.
- **IRREVOCABLE BENEFICIARY -** if applicable, must sign this form.

DEFINITIONS

***Beneficiary*:** A person who may become eligible to receive, or is receiving, benefits under a plan as a result of the insured's death. Each beneficiary will be considered a Primary Beneficiary unless otherwise designated.

Contingent Beneficiary: Person(s) named to receive benefits if the primary beneficiary is not alive.

Irrevocable Beneficiary: (1) A named beneficiary whose status as beneficiary cannot be changed without his or her permission. (2) Beneficiary whose rights to the policy cannot be changed or cancelled by the policyowner unless the beneficiary authorizes the transaction.

Owner: The person or other entity that enters into a contract of insurance with an insurer and owns the insurance policy. This person or entity has the entitlement to exercise the rights and privileges in the policy contract.

Payor: The party that the owner of the policy has designated as being responsible for paying the premiums on the policy.

***Primary Beneficiary*:** The party designated to receive the proceeds of a life insurance policy following the death of the insured.

***Revocable Beneficiary*:** A named beneficiary whose status as beneficiary can be changed without his or her permission. All beneficiaries will be assumed to be revocable unless specifically designated as irrevocable.

CHECKLIST

☐ Has the form been signed by all required parties?

- SECTION F MUST BE SIGNED BY THE CURRENT POLICYOWNER FOR ANY CHANGES TO BE VALID.
- If making beneficiary changes, current owner AND any irrevocable beneficiaries must sign in Section F
- If making a change to payor information, current owner must sign in Section F
- If making a legal name change, current owner must sign in Section F

☐ Do you live in a community property state or territory? If yes, complete Section E

☐ Has all required documentation been included with this form? (e.g., death certificate, copy of marriage certificate or divorce decree, court order, trust documentation)

Mailing Address: Colonial Penn Insurance Company
PO Box 1938, Carmel, IN 46082-1938
or submit by fax: (215) 928-8710

COLONIAL PENN INSURANCE COMPANY
PO Box 1938 • Carmel, IN 46082-1938
Customer Service: (800) 523-9100 Fax: (215) 928-8710

HEALTH POLICY INFORMATION FORM

Please print clearly in ink.

IMPORTANT NOTE: PLEASE COMPLETE SECTIONS A AND SIGN IN SECTION F TO ENSURE OUR RECORDS ARE COMPLETE AND UP TO DATE.

Policy Number	Primary Insured
Date	Owner (if other than Insured)

A OWNER/INSURED INFORMATION

For any corrections/changes to vital information (Name, DOB, SSN) please attach a copy of valid documentation to verify information.

☐ Owner ☐ Primary Insured

1. First Name	MI	Last Name	Date of Birth	SSN / TIN	
Address		City	State	Zip Code	
E-mail Address			Phone Number		

☐ Owner ☐ Primary Insured ☐ Secondary Insured

2. First Name	MI	Last Name	Date of Birth	SSN / TIN	
Address		City	State	Zip Code	
E-mail Address			Phone Number		

B BENEFICIARY INFORMATION

Please complete this section to confirm or change your beneficiary designation (designation does not apply to certain products!)

☐ Primary Beneficiary

1. First Name	MI	Last Name	Date of Birth	SSN / TIN		Percent of Proceeds
Address		City	State	Zip Code		
E-mail Address			Phone Number			

☐ Primary Beneficiary ☐ Contingent Beneficiary

2. First Name	MI	Last Name	Date of Birth	SSN / TIN		Percent of Proceeds
Address		City	State	Zip Code		
E-mail Address			Phone Number			

☐ Primary Beneficiary ☐ Contingent Beneficiary

3. First Name	MI	Last Name	Date of Birth	SSN / TIN		Percent of Proceeds
Address		City	State	Zip Code		
E-mail Address			Phone Number			

☐ Primary Beneficiary ☐ Contingent Beneficiary

4. First Name	MI	Last Name	Date of Birth	SSN / TIN		Percent of Proceeds
Address		City	State	Zip Code		
E-mail Address			Phone Number			

C PAYOR INFORMATION

To make changes to automatic bank draft, please contact our office at 800-523-9100 to obtain a change form.

Name (Please print full name)			
Address	City	State	Zip Code

D LEGAL NAME CHANGE

Former Name (Please print full name)	New Name (Please print full name)
Former Signature	New Signature

Reason for change and attach required documentation:

- ☐ Marriage / Divorce
- ☐ Court Order
- ☐ Trust Documentation
- ☐ Other

E RELEASE OF INTEREST IN COMMUNITY PROPERTY STATES OR TERRITORY

If you currently reside in a community property state or territory (Arizona, California, Idaho, Louisiana, New Mexico, Nevada, Texas, Washington, Wisconsin or Puerto Rico) please complete below:

If you have **never been married** please sign below:

Signature	Date

If you are **currently married** please have spouse sign below:

Spouse's Signature	Date

If you are **divorced** and the policy **was not** included in the Divorce Decree or your former spouse still retains a right to this policy, please have your former spouse sign below:

Former Spouse's Signature	Date

If you are **divorced** and your spouse relinquished their interest in the policy in the Divorce Decree and/or Property Settlement, please attach a certified copy of the Divorce Decree and/or Property Settlement.

If your spouse is **deceased**, please attach a copy of the death certificate.

F AUTHORIZATIONS / SIGNATURES

Policyowner's Signature(s) (and title, if corporation/business or trust owned)	Date
Irrevocable Beneficiary's Signature(s) (if applicable)	Date

Mailing Address: Colonial Penn Insurance Company
PO Box 1938, Carmel, IN 46082-1938
or submit by fax: (215) 928-8710