REQUEST FOR SERVICE

CHUBB®

Administrative Office:
PO Box 506
Keene NH 03431-0506
Fax: 603-357-4532

Complete this section for all requests		
(Last 4 digits of Social Security #)	Insured Name (First, Middle, Last):	Employer Name:
(Certificate #)	Certificateholder Name (First, Middle, Last):	Employer ID #:
Phone Number:	Fax Number:	

COMPLETE THE APPROPRIATE SECTION

☐ **1. ADDRESS CHANGE:** ***If changing the address for two or more individuals to the same address, check all appropriate boxes.***

ADDRESS CHANGE for: ☐ Insured ☐ Certificateholder ☐ Payor ☐ Secondary Addressee

Name: _____

Address: _____
(Street)

_____
(City/State/ZIP Code)

Day Phone #: (_____) _____ Evening Phone #: (_____) _____

☐ **2. NAME CHANGE (Legal Proof of Name Change is required):** ***To change the name of a Beneficiary or Assignee, use the beneficiary and assignment forms.***

Change name of: ☐ Insured ☐ Certificateholder ☐ Payor ☐ Secondary Addressee

_____ _____
From (*Former Name - Please Print*) To (*New Name - Please Print*)

Reason for Change: ☐ Marriage ☐ Divorce or resumption of former name
☐ Other _____
(*Please sign on page two with your new name*)

☐ **3. REDUCTION IN BENEFITS:**

☐ Cancel Certificate Number Above and Issue New Certificate with a Face Amount of _____
☐ Cancel Accidental Death Rider ☐ Cancel Accelerated Death Benefit for Long Term Care Rider
☐ Cancel Children's Term Rider ☐ Cancel Waiver Provision ☐ Other_____

☐ **4. SURRENDER OF CERTIFICATE:** ***Proceeds may be subject to federal and state income tax.***

☐ Total Surrender (*may be subject to company-imposed surrender penalties*)* $ _____
☐ *I Do ☐ *Do Not wish to have Federal Income Tax withheld from my proceeds.

☐ **5. INCREASE/CORRECTION IN BENEFITS:** ***Please complete and sign the attached application form(s).*** **An increase in benefits is not guaranteed and is subject to underwriting approval.**

☐ Add Rider

_____

☐ **6. REQUEST DUPLICATE CERTIFICATE:** ***Complete this section if original Certificate was lost.***

☐ Please send me a Confirmation of Insurance Coverage.
☐ Please send me a complete Duplicate Certificate.

☐ **7. PREMIUM/BILLING CHANGES to billing method or premium amount:**
If selecting pre-authorized checking, complete the authorization in Section 8 and attach a voided check.

New Premium Mode: ☐ Pre-authorized deductions from checking ☐ Direct Bill
New Premium Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

☐ **8. AUTHORIZATION FOR DEDUCTIONS FROM CHECKING:**
Complete and sign this section only if you selected pre-authorized deductions from your checking account.

I hereby authorize Combined Insurance Company of America to initiate premium deductions from my checking account. My bank is authorized to honor these drafts as if each were signed by me. This authorization shall remain in effect until revoked by me in writing and until my bank shall have received such notice. I agree that my bank shall be fully protected in honoring such draft. In order to stop payment, I must notify my bank in writing at least three (3) business days prior to the scheduled payment date. I agree that if any such check be dishonored whether with or without cause, my bank shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Name of Bank	Account Number	Draft Day
Bank Address	Signature of Depositor Attach "VOID" Sample Check	Date
City, State, Zip Code		Combine with Certificate #

☐ **9. OTHER CHANGES/COMMENTS: Complete this section to indicate any other contractual changes not covered elsewhere in this form except:**

- **to change a Beneficiary or Assignee, use the beneficiary and assignment forms, or**
- **to transfer Certificateholder, use the Certificateholder change request.**

_____
_____

SIGNATURES
Please refer to the signature instructions below.

I understand and agree that the above change(s) shall be subject to all terms and conditions of the Contract. The current Certificateholder must sign for any change.

X _____	*X* _____
Certificateholder	*Irrevocable Beneficiary/Assignee's Representative*
_____	_____
Date	*Date*

Spousal Consent for Community Property States: If the Certificateholder is a resident of AZ, CA, ID, LA, NV, NM, TX, WA, or WI, spousal consent is required unless the participant has no legal spouse. Please note, that without the spousal signature (if applicable), we will not be able to process the request.

_____ _____ ☐ Certificateholder has no legal spouse.
Spousal Signature *Date*

Signature Requirements
The Certificateholder's signature is required for all contractual changes. The Insured's signature is required on an application for increased coverage or change in Tobacco/Nicotine status if he or she is other than the Certificateholder and is not a minor. If in place, an irrevocable beneficiary's signature and/or assignee's signature are required for items 4 through 6. Always provide the date you signed the form.