

NATIONAL SECURITY INSURANCE COMPANY

661 East Davis Street • Elba, Alabama 36323

(334)897-2273

REQUEST FOR CHANGE IN POLICY - PART ONE

DISTRICT		DEBIT NO.		PAGE NO.		PHONE #			
POLICY NUMBER			INSURED			OWNER			
INSURED'S ADDRESS NUMBER/STREET		CITY		STATE		ZIP CODE		NEW ADDRESS? YES <input type="checkbox"/> NO <input type="checkbox"/>	INSURED'S SOCIAL SECURITY NUMBER
OWNER'S ADDRESS NUMBER/STREET		CITY		STATE		ZIP CODE		NEW ADDRESS? YES <input type="checkbox"/> NO <input type="checkbox"/>	OWNER'S SOCIAL SECURITY NUMBER

1.  CHANGE NAME OF  INSURED  BENEFICIARY  OWNER BY:  MARRIAGE  DIVORCE DECREE  LEGAL PROCESS\*  VOLUNTARY ADOPTION\*  
 \*DENOTES REQUIREMENTS FOR A CERTIFIED COPY OF COURT DECREE

PRESENT NAME (PLEASE PRINT) \_\_\_\_\_ ADDRESS \_\_\_\_\_

FORMER NAME \_\_\_\_\_

2.  TRANSFER OF OWNERSHIP: I, transfer all my rights, title and interest as owner of the above policy to:

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

TELEPHONE NUMBER \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

Subject to any loan made by the company and the security of the policy and to the rights of the company in connection therewith, and to any policy assignment in force and on file with the Company at its Home Office.

\_\_\_\_\_  
Signature of new owner

3.  CHANGE OF BENEFICIARY: All previous beneficiary designations are hereby revoked and the following beneficiary designation is made:

PRIMARY: \_\_\_\_\_  
(NAME) (DATE OF BIRTH) (RELATIONSHIP TO INSURED)

CONTINGENT: \_\_\_\_\_  
(NAME) (DATE OF BIRTH) (RELATIONSHIP TO INSURED)

4.  AFFIDAVIT OF LOSS AND REQUEST FOR DUPLICATE POLICY:

I request that the Company issue me a duplicate of policy number \_\_\_\_\_. I certify that I am the sole owner of the policy, that I have made a diligent search for the original policy and believe it to be lost beyond recovery. I agree to protect the Company against any claims that may arise from the original policy, to forward the original policy to the Company for cancellation if it should be found and to use the duplicate policy in place of the original for all purposes. That if said duplicate policy or certificate is issued, any payment made or privilege granted by the Company in accordance with such policy or certificate shall fully and finally discharge the Company of and from liability with respect to such payment or privilege.

5.  IS THE AUTOMATIC PREMIUM LOAN PROVISION DESIRED?  YES  NO

6.  POLICY LOAN:

- I REQUEST A POLICY LOAN OF THE MAXIMUM LOAN VALUE AVAILABLE. \_\_\_\_\_  
 I REQUEST A POLICY LOAN OF \$ \_\_\_\_\_ OR THE MAXIMUM AMOUNT, IF LESS.  
 I REQUEST A POLICY LOAN TO PAY PREMIUMS FOR THE DUE DATES OF \_\_\_\_\_

7.  EXTENDED TERM INSURANCE: I request that the Extended Term Insurance provision of the non-forfeiture section be applied, if available; and any election by me for application of the automatic premium loan provision now on file with the Company is hereby revoked.

8.  REDUCED PAID-UP INSURANCE:

I request that the Reduced Paid-up Insurance provision of the non-forfeiture section be applied, if available; and any election by me for application of the automatic premium loan provision now on file with the Company is hereby revoked.

9.  CASH SURRENDER REQUEST: (Send Policy)

I hereby apply for the cash surrender value of the above policy. In consideration of the payment to be made to me of the cash surrender value, I herewith surrender the policy to the Company for cancellation of all insurance thereunder and hereby release and forever discharge the Company from all claims under said surrendered policy. The election to surrender the policy shall not be effective until this application and the policy (or suitable evidence of lost policy) are received by the Company at the Home Office in Elba, Al.; and when so received, the Company's liability under said policy, except for the amount of the cash value, shall cease.

10.  SPECIAL REQUESTS: \_\_\_\_\_

The policy changes herein requested shall not be effective until an application is approved and policy delivered, and any necessary payments has been received by the Company. Change of beneficiary and/or change of ownership shall take effect on accordance with the provision(s) of the policy, except that it is agreed with the Insurance Company to waive any provision(s) of the policy requiring endorsements on the policy to effect the change(s) of said beneficiary and/or ownership. I request changes elected be recorded to my policy. By this election, I hereby revoke all other and former designations made by me. I make this election subject to all the conditions and provisions of said policy as well as any existing assignment. I represent and certify that no insolvency or bankruptcy proceedings are now against me.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_  
(City/State)

\_\_\_\_\_  
Witness (A non-relative adult)

\_\_\_\_\_  
Insured or Policy Owner

THE UNDERSIGNED AGREES TO THE ABOVE REQUEST

ABOVE CHANGE(S) RECORDED  
 NATIONAL SECURITY INSURANCE COMPANY

\_\_\_\_\_  
SIGNATURE OF ASSIGNEE (if any)

By \_\_\_\_\_ DATE \_\_\_\_\_

**NATIONAL SECURITY INSURANCE COMPANY  
REQUEST FOR CHANGE IN POLICY - PART TWO**

DISTRICT	DEBIT NO.	PAGE NO.
POLICY NUMBER	INSURED	OWNER

1.  TERM CONVERSION. (Send Policy, New Modal Premium and complete the beneficiary designation in Part One, Item 3 of this change form.) I request this term coverage to be converted as follows:
1. New contract type and Amount \_\_\_\_\_
  2. Original Date Conversion  Attained Age Conversion
  3. New Mode of Payment and Amount \_\_\_\_\_
  4. Automatic Premium Loan Provision elected  Yes  No
  5. If all of the Term Insurance is not to be converted, the remaining amount is to be  continued,  cancelled.
  6. Owner: Insured  Other than Insured  (Please specify) \_\_\_\_\_
  7. Other requests \_\_\_\_\_

Where no change is indicated, the information is to remain the same as in the original policy.  
If Premium Waiver, Accidental Death Benefit or additional riders are to be included in the new policy, always complete the request for addition of these benefits and complete application benefits, (Form No. B13-731 Rev. 97).

2.  BENEFITS. (Send Policy)
- |                          |                               |                                 |
|--------------------------|-------------------------------|---------------------------------|
| Waiver of Premium        | Add* <input type="checkbox"/> | Delete <input type="checkbox"/> |
| Accidental Death Benefit | <input type="checkbox"/>      | <input type="checkbox"/>        |
| Other _____              | <input type="checkbox"/>      | <input type="checkbox"/>        |
- \*Complete Application (Form No. B13-731 Rev.97).

3.  RIDERS. (Send Policy - Specify Type and Amount)
- |       |                               |                                 |
|-------|-------------------------------|---------------------------------|
| _____ | Add* <input type="checkbox"/> | Delete <input type="checkbox"/> |
| _____ | <input type="checkbox"/>      | <input type="checkbox"/>        |

If the rider to be added is a family plan rider or childrens insurance rider, list below the names, ages, and birthdates of persons eligilbe for coverage.

NAME	AGE	BIRTHDATE	SEX
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

\*Complete Application (Form No. B13-731 Rev. 97).

4.  CHANGE OF ORIGINAL POLICY ISSUE DATE. (Send Policy)
- Reinstatement By Redating - New Policy Issue Date \_\_\_\_\_
- Redate By Request (Please specify reason for request) \_\_\_\_\_
- New Policy Issue Date \_\_\_\_\_

5.  CHANGE OF FACE AMOUNT. (Send Policy)
- Increase Face Amount from \_\_\_\_\_ to \_\_\_\_\_
- Decrease Face Amount from \_\_\_\_\_ to \_\_\_\_\_

6.  CHANGE IN PLAN. (Send Policy)
- New Plan Type \_\_\_\_\_
- Mode of Payment and Amount \_\_\_\_\_

7.  ADD OR DELETE DEPENDENTS TO/FROM ACCIDENT AND HEALTH POLICIES.
- | NAME  | AGE   | BIRTHDATE | SEX   |
|-------|-------|-----------|-------|
| _____ | _____ | _____     | _____ |
| _____ | _____ | _____     | _____ |
| _____ | _____ | _____     | _____ |

Does the proposed insured(s) have or has he (they) ever had any disease or disorder or been treated by a physician within the last five years?  Yes  No  
If Yes, furnish complete details to include Doctors names and address.

8. CORRECTIONS AND AMMENDMENTS (HOME OFFICE USE ONLY)

By alteration of original policy or by substituting a rewritten policy in place thereof or by adjusting the Company's records of the original policy, the representations and agreements made in applying for the original policy or any reinstatement thereof shall remain in full force and apply to the new policy and be a part of the consideration for the issuance thereof. All statements and answers submitted to the Company for furnishing to it evidence of the insurability of the insured for the purpose of this change are to be considered on the basis of the insurance granted in reliance thereon, and the knowledge of the insured shall be deemed knowledge of each party signing such statements or answers.

If the original policy is assigned to the Insurance Company as collateral security for a policy loan or otherwise assigned, such agreements shall apply to the new policy instead of the original policy, the same as if such assignment had been made after the issuance of the new policy unless the assignment shall be released before the new policy is issued.

If said Company does not consent to alter, change, or rewrite said policy exactly as detailed above, said Company is hereby authorized to amend this request, and it is hereby agreed that the acceptance by the insured of any policy altered, changed or rewritten in accordance with this request as so amended, shall constitute a ratification of such amendment of this request.

I request that this change be recorded on the Policy. By this election I hereby revoke all other and former designations by me made. I make this election subject to all of the conditions and provisions of said Policy as well as any existing assignment. I represent and certify that no insolvency or bankruptcy proceedings are now pending against me.

DATED AT \_\_\_\_\_ THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_\_\_

CITY /STATE

_____ Witness ( A non-relative adult)	_____ Insured
THE UNDERSIGNED AGREES TO THE ABOVE REQUEST AND CHANGES	_____ Policy Owner

_____ Signature of Assignee (if any)	_____ Signature of Irrevocable Beneficiary (if any)
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Above changes recorded. NATIONAL SECURITY INSURANCE COMPANY By: \_\_\_\_\_ Date: \_\_\_\_\_