ManhattanLife

PO Box 926169
Houston, TX 77292
Fax: 1-855-710-6864

Voluntary Benefits Policy Service Request

Insured's Name:_____ Policy Number: _____
Owner's Name:_____
Owner's Social Security Number:_____
Owner's Address:_____
City:_____ State:_____ ZIP: _____
Owner's Telephone: (____) _____

(Policy Required if indicated)

☐ **Section A — Payor Address Change**
Address:_____
City: _____ State:_____ ZIP:_____

☐ **Section B — Legal Name Change** *(Does not change designation)*
☐ Beneficiary:_____
☐ Insured: _____
☐ Contingent Beneficiary:_____
☐ Applicant:_____
☐ Payor: _____
☐ Owner:_____

☐ **Section C — Premium Changes** *(Requires Home Office approval)*
Change Premium Payment: ☐ Annual ☐ Quarterly ☐ Monthly | ☐ Semi-annual Direct Bill ☐ Bank Draft *(Bank Authorization & voided check required)*

☐ **Section D — Convert Insurance To:**
Product/Plan: _____ Modal Premium: _____
Insurance Amount:_____ Effective Date: ____/____/____
☐ Continue Remaining Insurance
☐ Cancel Remaining Insurance

	Continue	**Terminate**
☐ Waiver of Premium	☐	☐
☐ AD&D Rider	☐	☐

Dividend Option:
☐ Paid in Cash
☐ Left to Accumulate

☐ **Section E — Policy Value Options** *(Premium must be current)*
I request that my policy be placed on: ☐ Reduced Paid-Up Insurance ☐ Extended Term Insurance
Discontinue Premium Payments Effective: ____/____/____

☐ **Section F — Plan Change, Reduction and/or Removal**
Requested Effective Date to Change Coverage: _____

☐ Change product/plan of insurance: From_____ to_____
☐ Reduce amount of insurance to:_____
☐ Remove Dependent, Benefit or Rider: _____

☐ Change Date of Birth to ____/____/____ Name of Insured that Change Applies to:_____

If the Policy requires that the above change(s) be endorsed in the Policy, it is requested that the Policy be modified to permit the change(s) without endorsement of the Policy.

_____ ____/____/____
Policy Owner Signature Date