



Allstate

Policyholder's Change and Service Request

For American Heritage Life Insurance Company (Home Office: Jacksonville, FL)

Workplace Division

Form with 8 sections: 1. Policy Changes, Reductions or Removals; 2. Annuity or UL Partial Surrender (Withdrawal); 3. Policy Loan; 4. Dividend Withdrawal; 5. Maturity Request; 6. Flexible Premium Payment Changes (FPA or UL only); 7. Change Name of; 8. Address Change. Includes checkboxes and text input fields.

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|--|---|--|
| Policy Number (use separate form per policy)   | Name of Insured (Last, First, Middle)   | Agent Name and Number (Please Print)   |
| <b>Take the following action(s) regarding this policy subject to AHL's current rules.</b>  |   |  |
| 9. <input type="checkbox"/> <b>Guaranteed Option Requests</b>  | <input type="checkbox"/> Change Automatic Option to (if applicable): <input type="checkbox"/> Reduced Paid-Up <input type="checkbox"/> Extended Term<br><input type="checkbox"/> Stop Premium and Adjust Coverage to (if applicable): <input type="checkbox"/> Reduced Paid-Up <input type="checkbox"/> Extended Term<br><small>*supplemental benefits cancel when premiums stop</small>  |  |
| 10. <input type="checkbox"/> <b>Transfer of ownership to</b><br><small>(Do not use for collateral assignment)</small>                            | All policy ownership rights will vest in the new owner shown below.<br>New Owner (Last, First, Middle) _____ Soc. Sec. # / F.E.I.N # _____<br>Address (Street, City, State, Zip) _____<br>At the death of the new owner, the successor owner is: <input type="checkbox"/> Insured, or <input type="checkbox"/> _____<br><small>*If a change of beneficiary is desired, it must be requested on form B-040, by the new owner.<br/> *This transfer is subject to the term of any irrevocable beneficiary designation in effect or any other ownership restrictions.</small>   |  |
| 11. <input type="checkbox"/> <b>Premium Mode Change to</b><br><small>(Direct Bill only)</small>  | <input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Pre-authorized Check Plan (PAC)<br><small>*PAC authorization and voided check required.</small>  |  |
| 12. <input type="checkbox"/> <b>Payroll Allotment Billing Changes</b>  | <input type="checkbox"/> Case No. _____<br><input type="checkbox"/> Control No. _____<br><input type="checkbox"/> Payor Name _____<br><input type="checkbox"/> Place policy on Direct Bill<br><input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Pre-authorized Check Plan (PAC)<br><small>*PAC authorization and voided check required.<br/> *At least one month's premium required. Check for \$ _____ attached.</small>  |  |
| 13. <input type="checkbox"/> <b>Application for Duplicate Policy or Certificate</b>  | I certify that the above policy has been lost or destroyed and that said policy is not assigned, hypothecated, or pledged in any way whatsoever. I, therefore, request the issuance of a duplicate of said policy and agree that should the original policy be found or in any way come into my possession, I will return or cause the same to be returned to American Heritage Life Insurance Company, its successors or assigns. It is distinctly understood and agreed that the original policy shall become null and void immediately upon issuance of the duplicate policy herein requested. I also agree that if duplicate forms of the lost policy are not available, I will accept a Certificate for Lost Policy. |  |
| 14. <input type="checkbox"/> <b>Other Instructions</b><br><small>(Be specific)</small>   |   |  |
| 15. <input type="checkbox"/> <b>Requested for Conversion to Individual Policy form Group Coverage</b><br><small>(Be Specific)</small>            | <input type="checkbox"/> Cancer <input type="checkbox"/> Other<br>Current Billing Address: _____<br>Employer: _____ Group Policy Number: _____<br>Certificate Number: _____<br>What policy do you want to convert to: _____<br>Application for the converted policy be made to us within 31 days (within 60 days of final divorce decree in case of divorce) after the coverage terminates. The effective date of the converted policy will be the date on which this coverage terminated.  |  |
| Note: For corporate owner, provide corporation's name, two officer's signatures and their titles   | Owner _____ Date _____<br>Owner _____ Date _____<br>Assignee (if applicable) _____ Date _____   |  |
| <b>Agent Use Only – Subject to AHL rules, send all items to be returned to:</b><br><input type="checkbox"/> Agent <input type="checkbox"/> Owner |   | <b>Home Office Use Only – Date Recorded</b> _____<br>By _____<br><b>To Be Effective On</b> _____ |