REQUEST FOR CHANGE

Accidental Death Insurance

Monumental Life Insurance Company, Cedar Rapids, IA

In addition to your Voluntary Coverage, your Financial Institution provides all insureds with Basic Accidental Death Coverage at no cost to you.

PLEASE CHECK (☑) ALL BOXES THAT APPLY:

❑ **INCREASE:** I presently have $_____ of insurance and wish to **INCREASE** my insurance to $ _____.
I understand there will be an increase in premium. *The maximum amount of voluntary coverage is $300,000.*
Coverage must be **INCREASED** in increments of $10,000.

❑ **DECREASE:** I presently have $_____ of insurance and wish to **DECREASE** my insurance to $ _____.
The minimum amount of voluntary coverage is $10,000. Coverage must be **DECREASED** in increments of $10,000.

❑ **CANCEL:** I presently have $_____ of insurance and wish to **CANCEL** my:

❑ **ADDITIONAL** insurance ❑ **ADDITIONAL** and $_____ **BASIC** insurance provided by the Financial Institution.

❑ **ADD FAMILY:** Please add family coverage. I currently have individual coverage and understand there will be an increase in premium.

❑ **CANCEL FAMILY**: Please cancel family coverage, however, keep my individual coverage in force.

❑ **NAME CHANGE**: Please change my name (Note: A copy of the legal document showing the name change must be included with this request.)

From: _____
FIRST MIDDLE LAST

To: _____
FIRST MIDDLE LAST

❑ **ADDRESS CHANGE**: Please change my address.

From: _____
ADDRESS CITY STATE ZIP

To: _____
ADDRESS CITY STATE ZIP

❑ **PREMIUM DEDUCTION ACCOUNT CHANGE**: Please change the account from which premium is deducted.

From: Account # _____ ❑ Checking ❑ Savings

To: Account# _____ ❑ Checking ❑ Savings

THE FOLLOWING MUST BE COMPLETED BEFORE THE ABOVE REQUESTED CHANGE(S) CAN BE MADE:

Insured's Name **(PLEASE PRINT):** _____ Insured's Date of Birth: _____/_____/_____

Financial Institution Name: _____ Account #: _____ ❑ Checking ❑ Savings

Insured's Signature: _____ Date: _____/_____/_____

RETURN TO:
Selman & Company, Customer Service Department, 6110 Parkland Boulevard, Cleveland, Ohio 44124-4187
Phone: 877-665-7563
PLEASE RETAIN A COPY OF COMPLETED FORM FOR YOUR FILES