

Washington National Insurance Company  
P.O. Box 1957  
Carmel, Indiana 46082-1957

**POLICY/CERTIFICATE INFORMATION UPDATES**

**Instructions: Please answer all questions for the change(s) you would like made to your coverage record. If any additional information is required, be sure to send it with this form. The Company will process and notify you in writing of the approved change and effective date.**

POLICY/CERTIFICATE NUMBERS \_\_\_\_\_

POLICYOWNER/CERTIFICATEHOLDER'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

DAYTIME PHONE # ( ) \_\_\_\_\_

**CHANGE OF MAILING ADDRESS** – Communications concerning this policy/certificate are to be mailed to the following new address:

**NEW ADDRESS:**  
STREET ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

**BENEFICIARY DESIGNATION** – All previous beneficiary designations are hereby revoked. The Company is free from liability in relying on a statement about birth, death, marriage, names and addresses and other facts concerning all beneficiaries.

Unless otherwise stated in the policy/certificate, the survivors of a beneficiary class share equal amounts of the proceeds.

BENEFICIARY'S FULL NAME, ADDRESS	Relationship	Percentage of Total
Primary: _____	_____	_____
Contingent: _____	_____	_____
Primary: _____	_____	_____
Contingent: _____	_____	_____

*If none of the above are living or this designation is ineffective, proceeds will be paid as stated in the policy/certificate. If a Trust is named as the Beneficiary, a certified copy of the Trust is required. Please note this section is only applicable for Accident or Life Insurance.*

**CORRECTION OR CHANGE OF NAME OF POLICYOWNER/CERTIFICATEHOLDER/INSURED**

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

Reason  Marriage\*  Change by Court Order on \_\_\_\_\_\*  Correction

Resumption of maiden name \_\_\_\_\_\*

Date Name Changed \_\_\_\_\_ \*Certified copy of Court documentation required

## REQUEST FOR DECREASE IN COVERAGE

**Note:** This section is for **decreasing** your level of benefits within a program, removing a family member or deleting an optional rider from your coverage. If you want to **increase** your level of benefits, and/or add a family member or add an optional rider, please complete the appropriate application, available from your agent or the company.

Policy Number	Product Type (ex: cancer, heart, life accident etc.,)	Remove		Decrease Benefit Level	Detailed Description of Requested Change
		Rider	Person		
EXAMPLE	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Plan decrease my coverage from a Plan D to a Plan A
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Are you requesting to remove the Policyowner/Certificateholder due to death? If "yes", please forward a copy of the death certificate with this form.	<input type="checkbox"/> Yes <input type="checkbox"/> No
After removing the person listed above and/or decreasing your benefits are there any dependents (spouse, children) that will still remain under your coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you removing an existing Return of Premium or Cash Value rider? If "yes", you must complete a Forfeiture of Benefits form.	<input type="checkbox"/> Yes <input type="checkbox"/> No

## LIFE COMMUNITY PROPERTY STATES

If you currently reside in one of the following states (or **Puerto Rico**) please complete the additional information below: **Arizona, California, Idaho, Louisiana, New Mexico, Nevada, Texas, Washington, or Wisconsin.**

1. If you have never been married, please acknowledge by signing and dating below:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

2. If you are currently married, Your spouse must consent to the transaction by signing and dating below:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

3. If you spouse is deceased, please attach a copy of the Death Certificate.

4. If you are divorced: A. and the policy was included in the Divorce Decree or Property Settlement Agreement and was awarded to you please attach a certified copy of the document. Spouse's consent not required.  
B. and the policy was not included in the Divorce Decree or Property Settlement Agreement, it will be necessary for your ex-spouse to consent by signing below:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Unless the Company has been notified of a community property interest in this policy, the Company shall be entitled to rely on its good faith belief that no such interest exists and assumes no responsibility for inquiry. The insured and/or policyowner signing this form agree to indemnify and hold the Company harmless from the consequences of accepting this transaction.

**By my signature below I hereby authorize the company to make coverage changes as I have indicated above. I understand that such changes will not take effect until they have been approved by the Company and I have been notified of the effective date.**

X \_\_\_\_\_  
Signature of Policyowner/Certificateholder/Insured Date

The person signing this form agrees to indemnify and hold harmless the Company from the consequences of accepting this transaction.

NOTE: Subject to receipt of this request by the Company, I hereby revoke and cancel any prior request of election which I have made.