NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY

4949 Keller Springs Road ● Addison, Texas 75001 ● (888) 671-6771

HOW TO MAKE CHANGES IN YOUR INSURANCE (OTHER THAN CHANGES IN BENEFITS)

This request for change should be completed as indicated and submitted to us at the address listed above.

Complete only the page applicable to the change you need and return only that page to us. Be sure to include the insured's name, social security number and policy number on all pages returned to us. Mark the box by each section for which you are making changes.

Please print all information and use ballpoint pen.

Sign and date sections where indicated for requested changes. Upon approval by National Teachers Associates Life Insurance Company, a copy will be returned.

1. **Change of Name or Personal Information.** Indicate for whom the change is needed and the reason. Please attach a copy of legal evidence of the name change (marriage certificate, decree of divorce, etc.). Attach a supplemental page for multiple changes. ***Policyowner's signature is required.***
2. **Change of Payor**. Use this section if you need to change the person that pays the policy premium(s). If the method of payment is changing (*i.e.,* credit card or bank draft), you will also need to complete the Bank Draft Authorization or Credit Card Payment Authorization Form (75-306) available for download under the Customer Service page of our website, www.ntalife.com. You can also request the form by calling our Customer Service Department toll free at (888) 671-6771. ***Policyowner's signature is required.***
3. **Change of School or Employer's Name and/or Address.** If the place of business where your premiums are billed has had a change, please indicate your information in this section. ***Policyowner's signature is required.***
4. **Delete Covered Persons.** Indicate the individual you wish to delete as a Covered Person and the effective date of the change. Also, indicate if coverage is being reduced to Single Parent Plan or Individual Plan. ***Policyowner's signature is required.***

   <u>This form cannot be used to add Covered Persons to your coverage</u>. To add a covered person to your policy, a complete application must be submitted for underwriting approval. If you are adding a child over 18 years of age, evidence of full-time enrollment in an accredited college or university or a physician's statement of medical incapacity must accompany your request.
5. **Change of Beneficiary.** Print name(s) in full and give address and relationship of each person to insured. ***Policyowner's signature is required.***
6. **Change of Ownership.** Print name(s) of new owner in full and give address and relationship of each person to insured. ***Policyowner's signature is required.*** If you are naming a co-owner, the co-owner's name and signature is required.
7. **Additional Service Requested.** Please explain. ***Policyowner's signature is required.***

75-334 (2/06)

Policyowner Information

This information must be completed for all requests.

PRIMARY INSURED: ____________________

CURRENT POLICYOWNER: ____________________

POLICY #(S): ____________________ **SOCIAL SECURITY #:** ____________________

MAILING ADDRESS: ____________________

____

TELEPHONE: Business: ____________________ **Home:** ____________________

Cell: ____________________

BEST TIME TO CALL (8 AM – 5 PM CST): ____________________

I (We), the owner(s) of the above numbered policy, hereby request that the policy be changed as follows:

☐ **1. CHANGE OF NAME OR PERSONAL INFORMATION FOR A PRIMARY INSURED, BENEFICIARY OR OWNER.** If you would like to name a new beneficiary, please complete Section 5.

Previous Name/Address/Phone: ____________________

____

New Name/Address/Phone: ____________________

____

Correction to Social Security Number ____________________ Correction to Date of Birth ____________________

Current email address ____________________

Person whose name or address has changed ______Insured _____ Beneficiary _____Policyowner ______Payor

Please include the appropriate legal documentation to support your request for a name change.

____________________ Owner's Signature ____________________ Date

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☐ **2. CHANGE OF PAYOR.** If method of payment is changing to bank draft or credit card, then you must also attach a completed Bank Draft Authorization/Credit Card Payment Authorization Form (75-306).

CURRENT PAYOR:

Name ____________________

Address ____________________

____

Effective Date ____________________

NEW PAYOR:

Name ____________________

Address ____________________

____

Phone ____________________

Relationship to Insured ____________________

____________________ Owner's Signature ____________________ Date

DO NOT WRITE BELOW THIS LINE

75-334 (2/06)

Date Approved____________________

By____________________

For **NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY**

☐ **3. CHANGE OF SCHOOL/EMPLOYER'S NAME AND/OR ADDRESS.**

Previous School/Employerl____Group#________________

New Employer____

New Address ____

____Phone _________________________

Attention ____

____ ________________________

Owner's Signature Date

☐ **4. DELETE COVERED PERSON / REDUCE COVERED PERSONS PLAN TYPE.**

Name of Person to Delete from Coverage: ____

Change to Individual Plan ______________ Change to Single Parent Plan ________________

Effective Date of Change Requested ____

____ ________________________

Owner's Signature Date

☐ **5. REQUEST FOR CHANGE IN BENEFICIARY.** For each person, include **full name, address, social security number, telephone number and relationship to the Insured**. If more than one person is named as beneficiary, benefits will be paid in equal shares to the survivor or survivors, unless indicated otherwise.

Primary Beneficiary(ies): ____

Full Name SSN

____

Address City State Zip

OTHERWISE TO:
Secondary Beneficiary(ies): ____

Full Name SSN

____

Address City State Zip

If no beneficiary survives the Insured, the proceeds will be paid as provided in the policy. If no provision is made in the policy, then proceeds will be paid to the estate of the Insured. Unless otherwise stated in the policy, the owner(s) reserve(s) the right to change the beneficiary designation without the beneficiary's consent. It is understood that this request for change will become a part of the policy. It will take effect as of the date such request was made, as indicated below, thereby revoking all prior beneficiary designations, subject to any payment the Company made or other action it took before receiving and recording the request.

Signed at: ______________________________ on ________________________, 20____.

City State Date

____ ____

Owner Witness to Owner's Signature

____ ____

Co-Owner and/or Irrevocable Beneficiary (if applicable) Witness to Signature

DO NOT WRITE BELOW THIS LINE

75-334 (2/06)

Date Approved______________________________________

By____

For **NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY**

❑ **6. REQUEST FOR CHANGE OF OWNERSHIP.**

NEW OWNER:
Name ____
Address ______________________________________
____
Phone ____
Taxpayer ID ___________________________________
Relationship to Insured ___________________________

NEW OWNER: (if there are to be co-owners):
Name ____
Address ______________________________________
____
Phone ____
Taxpayer ID ___________________________________
Relationship to Insured ___________________________

CONTINGENT OWNER (if any):
Name _____________________________________
Address ___________________________________
____
Relationship to Insured _________________________

FUTURE PREMIUM NOTICES SENT TO (if to be changed):
Name ____
Address _______________________________________
____

I (We), the current owner(s) of the referenced numbered policy, hereby request that the ownership of this policy be changed to the person(s) shown above as the new owner(s). The new owner(s) will be the absolute owner(s) of this policy (subject to the rights of any prior assignee) during his or her lifetime. At the death of a new owner, ownership of this policy will pass to the co-owner while living, if any; then to the contingent owner while living, if any; then to the Executors, Administrators or Assigns of the most recent owner.

It is understood that this request for change will become a part of the policy; and will take effect as of the date such request was made, as indicated below, subject to any action the Company took prior to receiving and recording this request.

Signed at: ______________________________________ on ________________________________, 20____.
City State Date

Current Owner(s)	Witness to opposite signature
New Owner(s)Witness to opposite signature	Witness to opposite signature
Contingent Owner (if any)	Witness to opposite signature

❑ **7. ADDITIONAL SERVICE REQUEST.** ____

____
____
____
____

Owner's Signature Date

DO NOT WRITE BELOW THIS LINE

75-334 (2/06)

Date Approved____

By____
For **NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY**