

**TRUSTMARK**  
P.O. BOX 7930  
LAKE FOREST, ILLINOIS 60045  
1-800-918-8877

**POLICYOWNER SERVICE REQUEST FORM**

PLEASE PRINT OR TYPE EXCEPT WHERE SIGNATURES ARE REQUESTED.  
COMPLETE THIS SECTION AND SELECT CHANGES DESIRED.

Account No. \_\_\_\_\_ Cert/Policy No. \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Insured's Address, City, State, Zip Code: \_\_\_\_\_

Insured's Phone Number: (        ) \_\_\_\_\_

**1. CHANGE OF OWNERSHIP BY ABSOLUTE ASSIGNMENT**

*RETURN THE ORIGINAL CERTIFICATE/POLICY. IF IT WAS LOST OR DESTROYED DESCRIBE CIRCUMSTANCES.*

\_\_\_\_\_

As current owner of this certificate/policy, I absolutely assign all of my rights of ownership in the certificate/policy to the new owner listed below. This request shall not change the beneficiary on record or mode of payment as a death benefit. If a change of beneficiary is desired, the new owner must complete the "Change of Beneficiary" designation on page 2.

New Owner Name: \_\_\_\_\_

New Owner Social Security Number: \_\_\_\_\_

New Owner Address: \_\_\_\_\_

New Owner City, State, Zip Code: \_\_\_\_\_

New Owner Telephone Number: (        ) \_\_\_\_\_

Substitute W-9 Information for New Owner:

Have you been notified by the Internal Revenue Service that you are subject to back-up withholding?  YES  NO

Do you want Trustmark to withhold 20% of your taxable interest income?  YES  NO

**NEW OWNER SIGNATURE(S):** \_\_\_\_\_

*IF THE NEW OWNER IS ALSO THE INSURED DO NOT COMPLETE CONTINGENT OWNER*

Contingent Owner Name: \_\_\_\_\_

Contingent Owner Social Security Number: \_\_\_\_\_

Contingent Owner Address: \_\_\_\_\_

Contingent Owner City, State, Zip Code: \_\_\_\_\_

Contingent Owner Telephone Number: (        ) \_\_\_\_\_

Substitute W-9 Information for Contingent Owner:

Have you been notified by the Internal Revenue Service that you are subject to back-up withholding?  YES  NO

Do you want Trustmark to withhold 20% of your taxable interest income?  YES  NO

**CONTINGENT OWNER SIGNATURE(S) (IF ADULT):** \_\_\_\_\_

**2. CHANGE OF BENEFICIARY**

1. All beneficiary designations on the certificate/policy made prior to this date are revoked.
2. If you live in Arizona, California, Idaho, Louisiana, New Mexico, Nevada, Texas, Washington or Wisconsin, your spouse must sign this form as you reside in a Community Property State.
3. The beneficiary or beneficiaries on the certificate/policy from this date shall be as follows:

PRIMARY BENEFICIARY	BENEFICIARY'S ADDRESS	RELATIONSHIP

*if living, otherwise*

CONTINGENT BENEFICIARY(S)	BENEFICIARY'S ADDRESS	RELATIONSHIP

*equally or to the survivor or survivors. If all designated beneficiaries predecease you, your beneficiary will be your Estate.*

Any certificate/policy provision which requires endorsement of a beneficiary change on the certificate/policy form is deleted by mutual agreement of the owner and the Company. The beneficiary may be changed at any time during the Insured's lifetime by written request satisfactory to the Company. Such change will be binding on the Company only when received at its Home Office, but when received shall take effect as of the date it was signed by the owner, subject to any action taken or payment made by the Company before receipt and regardless of whether or not the Insured is living on the date of the receipt. This designation is made subject to all other terms and conditions of the certificate/policy and any assignments on record with the Company.

**3. CHANGE OF NAME**       Insured       Owner       Payor

From: \_\_\_\_\_ To: \_\_\_\_\_  
                    First                      Middle                      Last                      First                      Middle                      Last

Reason: \_\_\_\_\_ Date of Marriage: \_\_\_\_\_

**4. CHANGE OF AGE AND BIRTH DATE**      *(Attach Birth Certificate to this form)*

Change Age of Insured to \_\_\_\_\_ Correct Date of Birth \_\_\_\_\_

**5. CHANGE OF PREMIUM PAYMENT FREQUENCY**

- Monthly       Quarterly       Semi-Annual       Annual
- P.R.D. (Attach Payroll Deduction Authorization)       Allotment (Attach Allotment Authorization)
- C.O.M. (Attach Request for Check-O-Matic Plan plus a sample check)

**6. REDUCTION IN AMOUNT OF INSURANCE**

Universal Life – Reduce Face Amount to \$ \_\_\_\_\_ and monthly premium to \$ \_\_\_\_\_.

Disability – Reduce Monthly Benefit to \$ \_\_\_\_\_.

**7. LOST CERTIFICATE/POLICY**

I hereby declare that my certificate/policy was lost or destroyed under the following circumstances:

\_\_\_\_\_

This Certificate/Policy has not been assigned as collateral security, except as noted below:

- I hereby request issue of a duplicate certificate/policy or Summary of Benefits if the certificate/policy is no longer printed.

**8. CERTIFICATE/POLICY LOAN**

I request a loan of \$ \_\_\_\_\_ or the maximum amount if less.

9. REMOVAL OF BENEFIT RIDERS

Remove:

- Waiver of Premium
- Accidental Death Benefit
- Child Term Insurance Rider \_\_\_\_\_ units
- Other Insured Term Insurance Rider

Name of Insured to be removed \_\_\_\_\_

- Other, please specify \_\_\_\_\_

10. PARTIAL WITHDRAWAL

- Maximum amount available
- Amount \$ \_\_\_\_\_

Only one partial withdrawal will be allowed during each certificate/policy year. Your request must be made prior to the maturity date during the Insured's lifetime. Each withdrawal must be at least \$100. A partial withdrawal charge, as shown in the schedule, will be deducted each time this is done. We will not permit a partial withdrawal to reduce the cash value below a sum equal to two monthly deductions.

A partial withdrawal will result in a reduction of the cash value, accumulated value and the death benefit amount by the amount of such partial withdrawal.

11. LIFE SURRENDER

I request the cash surrender value of my certificate/policy, less any outstanding loan.

- I am returning the original certificate/policy
- The certificate/policy was lost or destroyed under the following circumstances:

\_\_\_\_\_

Owner's Social Security Number: \_\_\_\_\_

**IMPORTANT TAX INFORMATION**

Substitute W-9 Information for Owner:

Have you been notified by the Internal Revenue Service that you are subject to back-up withholding?

- YES  NO

Do you want Trustmark to withhold 20% of your taxable interest income?  YES  NO

12. CHANGING THE DEATH BENEFIT OPTION

- 1. If You request a change from Option A to Option B: The new Face Amount will be the Death Benefit Amount less the Accumulated Value as of the effective date of the change, but not less than zero.
- 2. If You request a change from Option B to Option A: The new Face Amount will be the Death Benefit Amount as of the effective date of the change.

\* We may require evidence of insurability for a change in the Death Benefit Option if the net amount at risk is being changed. The change will go into effect on the monthly deduction day following the date we receive your request for change, subject to our approval of the change.

**AGREEMENT AND SIGNATURE SECTION**

I (we) request that all transactions marked above be completed by Trustmark and I (we) expressly warrant that all persons signing below are of legal age and that no proceedings in bankruptcy are pending against any of them. The changes requested in this form will not become effective until approved by Trustmark.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.  
City and State

Signature of Current Owner(s): \_\_\_\_\_

Signature of New Owner(s): \_\_\_\_\_

If Change of Beneficiary and you reside in Arizona, California, Idaho, Louisiana, New Mexico, Nevada, Texas, Washington or Wisconsin, which are Community Property States your Spouse **MUST** sign here: \_\_\_\_\_

Witness (Not Related/Agent) Signature: \_\_\_\_\_

**THIS SECTION FOR OFFICE USE ONLY**

Received in Trustmark, Lake Forest, Illinois this \_\_\_\_\_ day of \_\_\_\_\_.

Changes made \_\_\_\_\_ . Approved by \_\_\_\_\_

Please attach copy to certificate/policy number \_\_\_\_\_ .