



# Request for Service Form

## Section 1 – General information (please use blue or black ink to complete this form)

|                                                                                       |  |                     |  |        |      |
|---------------------------------------------------------------------------------------|--|---------------------|--|--------|------|
| Insured's name:<br>(As currently listed on the policy/certificate)                    |  | DOB: ____/____/____ |  | SSN:   |      |
| Address:                                                                              |  | City:               |  | State: | ZIP: |
| Telephone:                                                                            |  | Mobile:             |  | Email: |      |
| List all policy/certificate numbers related to this request:<br>(Required to process) |  |                     |  |        |      |
| Employer:                                                                             |  |                     |  |        |      |

☐ Please check if the address above is new.

## Section 2 – Name change

|           |          |                                                                                                                        |
|-----------|----------|------------------------------------------------------------------------------------------------------------------------|
| Previous: | Current: | Reason: <input type="checkbox"/> Marriage/Divorce <input type="checkbox"/> Correction* <input type="checkbox"/> Other* |
|-----------|----------|------------------------------------------------------------------------------------------------------------------------|

\*A copy of legal documentation is required unless your name is changing due to reason of marriage or divorce.

## Section 3 – Premium payment method change (select only **ONE** option)

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> <b>1. Deduct premiums monthly from my bank account.</b><br><input type="checkbox"/> 1st-5th <input type="checkbox"/> 6th-10th <input type="checkbox"/> 11th-15th <input type="checkbox"/> 16th-20th <input type="checkbox"/> 21st-26th<br>Your draft will occur on one of the dates within the range you have selected. Please include a voided check or _____<br>Routing # _____ and Account # _____ Signature of bank account owner                                                                                         |  |
| <input type="checkbox"/> <b>2. Bill me directly. (Choose one of the following)</b><br><div style="display: flex; justify-content: space-around;"> <div> <input type="checkbox"/> <b>Quarterly</b><br/>           (Submit a payment 3 times your monthly premium)         </div> <div> <input type="checkbox"/> <b>Semi-annually</b><br/>           (Submit a payment 6 times your monthly premium)         </div> <div> <input type="checkbox"/> <b>Annually</b><br/>           (Submit a payment 12 times your monthly premium)         </div> </div> |  |
| <input type="checkbox"/> <b>3. Change to payroll deductions</b> (Please contact your Plan Administrator to start payroll deduction.)<br>Employer: _____ Billing control/account number: _____                                                                                                                                                                                                                                                                                                                                                          |  |

## Section 4 – Policy/Certificate Change (select only **ONE** option)

Change Policy/Certificate to:

|                                                        |                                                                     |                                                               |                                                                |                                                          |
|--------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Family Coverage to Individual | <input type="checkbox"/> Family Coverage to Employee + Dependent(s) | <input type="checkbox"/> Family Coverage to Employee + Spouse | <input type="checkbox"/> Employee + Dependent(s) to Individual | <input type="checkbox"/> Employee + Spouse to Individual |
|--------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------|

Spouse/Child Continuation:

|                                                                                                                                                                                |      |      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------|
| Provide name, date of birth (DOB) and Social Security number (SSN) for spouse/dependent(s) continuation. If more space is needed, please provide the information in Section 7. |      |      |
| Name:                                                                                                                                                                          | DOB: | SSN: |
| Name:                                                                                                                                                                          | DOB: | SSN: |

## Section 5 – Cancellation and/or Surrender (also complete section 6 for surrender only)

All Requests will be completed within 30 Days.

|                                                                                                                                                              |                                              |                                                                                                                                                                 |                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> <b>Cancel/surrender the policy(ies)/certificate(s)</b> (This option will cancel or cash surrender your policy(ies)/certificate(s).) |                                              |                                                                                                                                                                 |                                                             |
| <input type="checkbox"/> <b>Cancel the following riders on the policy(ies)/certificate(s):</b><br>(This option will cancel policy/certificate riders only.)  | <input type="checkbox"/> <b>Spouse Rider</b> | <input type="checkbox"/> <b>Dependent Rider</b> (This will cancel coverage for ALL dependents.) List date of birth of youngest dependent:<br>(MM/DD/YYYY) _____ | <input type="checkbox"/> <b>Other</b> (name rider)<br>_____ |

**Pre-Tax Policy:** Policy changes requested on Pre-Tax policies outside of Open Enrollment may require approval from your employer except for a qualifying event.

## Section 6 – Tax withholding options

Choose one of the following options.  
If an option is not selected, a withholding will automatically be made.

- ☐ I DO NOT want to have Federal Income Tax withheld in conjunction with this surrender/partial surrender/withdrawal proceeds.
- ☐ I DO want to have Federal Income Tax withheld in conjunction with this surrender/partial surrender/withdrawal proceeds.

Election of a tax withholding option is not available for tax-qualified products. The insurer is required to withhold 20% of any recognized gain for tax-qualified products unless proceeds are rolled directly into an IRA or other qualified retirement plan.

Under certain criteria established by the Treasury Department, a gain may be reportable by the insurer at the time of surrender, partial surrender or withdrawal of this policy, creating a taxable situation. However, any gain is taxable income for the current tax year.

If a gain is reportable, an IRS Form 1099R will be sent to you at the beginning of the next calendar year reporting the recognized gain, and a copy of IRS Form 1099R will be sent to the IRS. If a gain is not reportable when the surrender, partial surrender or withdrawal is processed, an IRS Form 1099R will not be sent. In addition, if a gain is reportable, the insurer is required to withhold 10% of any recognized gain, unless the policy owner elects not to have the tax withheld. You may be subject to penalties under the estimated tax payment rules if you elect not to have tax withheld and payments of estimated tax and other withholding are not adequate to satisfy tax liability.

## Section 7 – Other requests or remarks

|  |
|--|
|  |
|  |
|  |
|  |

## Section 8 – Signatures required (this section MUST be complete in order for us to process your request)

**Special notice for Residents of a Community Property State:** A spouse or former spouse may have an interest in life insurance proceeds or any accumulated cash value if the policy premiums were paid with community funds. It is your responsibility to consult your legal advisor to 1) ensure that any required consent from a spouse or former spouse has been received and 2) ensure that your spouse or former spouse will not be able to make a claim against any policy values and/or the proceeds in the event any policy benefits become payable.

I have carefully read this request and agree that it is properly and fully completed. I understand that this request is subject to the provisions and conditions of the policy/certificate and that the company may require additional information or requirements. I certify that the policy/certificate is not pledged or assigned to any other person or corporation, except where stated in the request, and that no proceedings or bankruptcy or insolvency have been filed or are now pending. **I certify the Social Security number and date of birth indicated are correct, and I hereby authorize Colonial Life to execute this request.**

**X** \_\_\_\_\_  
Policy/certificate owner's signature Date (MM/DD/YYYY)

Assignee's signature (if any):

Date (MM/DD/YYYY):

|                                        |             |                     |      |
|----------------------------------------|-------------|---------------------|------|
| Policy/certificate owner's information | Print name: | DOB: ____/____/____ | SSN: |
| Address:                               | City:       | State:              | ZIP: |
| Telephone:                             | Email:      |                     |      |

**Fax this form: 1-800-561-3082**  
**Or mail: P.O. Box 1365, Columbia, SC 29202**