CUSTOMER SERVICE REQUEST

Policy number	Insured	Policyowner (If other than insured)

MAIL CHECK, CHANGE ADDRESS OR REPLY TO:

Address ____

____

Telephone: (Residence)______________________ (Business) ______________________ (Cellular) ______________________

E-mail address: ____

PLEASE PROCESS AS INDICATED BELOW:

☐ **1. POLICY LOAN**

Make policy loan ☐ For maximum amount ☐ Specified amount $______________

☐ To pay premium due ______________ for policy no. ____________________

LOAN AGREEMENT
In consideration of the advance by Best Meridian Insurance Company, as a loan, all rights, title and interest in the policy is assigned to the Company as sole security for the repayment of the loan with interest subject to the provisions of the policy.

I certify that no bankruptcy proceedings, attachment, tax or other lien or claim is now pending against the policyowner.

☐ **2. PARTIAL SURRENDER**

☐ Maximum amount ☐ Specified amount $ ____________________

☐ **3. FULL SURRENDER (Policy must be returned)**

The cash surrender value is requested and it will be accepted as full payment and release of all claims under the policy. The surrender will be effective when it is received by the Home Office at Coral Gables, Florida.

☐ Forward check for the proceeds after deduction of indebtedness, if any

☐ Apply the proceeds as follows: ____

I certify that no bankruptcy proceedings, attachment, tax or other lien or claim is now pending against the policyowner.

☐ **4. MODE OF PREMIUM PAYMENT**

Please change mode of premium payment to: ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly* ☐ Check-o-matic

*Available only for automatic credit card payments via Internet.

☐ **5. GUARANTEED VALUES OR NONFORFEITURE OPTIONS (Policy must be returned)**

Transfer policy to ☐ Reduced paid-up insurance (Benefits and riders, if any, will be cancelled)

☐ Extended term insurance

☐ **6. DUPLICATE POLICY OR POLICY CERTIFICATE**

I certify that I have been unable to find the above described policy and I further certify that the policy is not assigned or pledge. I request the issuance of a duplicate policy, or certificate of insurance should duplicate policy not be available. I agree that (a) upon issuance of a duplicate policy or certificate, the original policy shall be null and void, and (b) if the original policy is found, it will be immediately returned to Best Meridian Insurance Company. I agree to hold the Company harmless from any claim or expense under the original policy.

☐ **7. AGE CORRECTION (Policy must be returned)**

☐ Insured ☐ Spouse ☐ Correct date of birth ____

(If the change is to a younger age submit proof of birth)

☐ I wish to continue present premium, adjust amount of insurance

☐ I wish to continue same amount of insurance, adjust premium

(SIGNATURES ON FOLLOWING PAGE)

☐ 8. NAME CHANGE

Change name of ☐ Insured ☐ Policyowner ☐ Beneficiary

From (Please print former name) To (Please print new name)

Reason for change: ________________________ (If other than marriage, divorce or correction, please attach copy of legal evidence)

☐ 9. OWNERSHIP CHANGE

Transfer ownership of policy to: I.D. number (Please send copy):

Upon the death of the new owner, the owner shall be:

☐ Insured

☐ Other ____

Address of new owner ____

☐ 10. BENEFICIARY CHANGE (If there is a minor as beneficiary, please designate a custodian)

Change beneficiary to:	Print full name	Date of birth	I.D. Number	Relationship
Primary beneficiary				
Contingent beneficiary				

I hereby designate ______________________________ as custodian for the minors named as beneficiaries on the above-referenced insurance policy under the Florida Uniform Transfers to Minors Act.

Best Meridian Insurance Company (BMIC) shall not be responsible for the application or disposition of the insurance proceeds by said custodian and the receipt by such custodian shall be full discharge of BMIC's liability under the life insurance plan.

Proceeds will be paid in equal shares to primary beneficiaries who survive the insured, but if none survive the insured, proceeds will be paid in equal shares to contingent beneficiaries if any are living. (If common disaster provision is desired, check box 13). This change cancels any previous beneficiary designation or settlement agreement.

☐ 11. COMMON DISASTER PROVISION

Do not make payment of the proceeds until 30 days after the insured's death. If any beneficiary dies before the end of such 30 day period, make payment as though such beneficiary had died before the insured.

☐ 12. CANCELLATION OF RIDERS AND/OR AGREEMENTS (Policy must be returned)

Cancel the following:

☐ Accidental death benefit ☐ Disability waiver of premium ☐ Other ______________________

☐ 13. ADDITIONAL REQUEST (Any other changes not listed above)

I/We agree that my(our) signature(s) below shall apply to each request which has been checked on both sides of this form.

Date ____________ Signature of policyowner (If owned by a company, show title) ____________

Signature of irrevocable beneficiary (if any) ____________ Signature of new policyowner ____________

FOR INSURANCE COMPANY USE ONLY

Registered by Best Meridian Insurance Company, Coral Gables, Florida on the ________ day of ______________________ of 20_____

Signature of authorized policyholder services representative