

# Federal Life Insurance Company (Mutual)

3750 West Deerfield Road • Riverwoods, Illinois 60015-3598

1-800-233-3750

## REQUEST FOR CONTRACT CHANGE OR AMENDMENT OF APPLICATION / ENROLLMENT FORM

Contract No. \_\_\_\_\_ Insured \_\_\_\_\_ Owner \_\_\_\_\_

1. CHANGE NAME of  Insured  Owner  Payor

Former Name \_\_\_\_\_ New Name (Please Print) \_\_\_\_\_

Reason for change:  Marriage  Divorce  Correction  Court Order  Adoption Legal change date \_\_\_\_\_  
Please provide legal evidence if name change is due to Court Order or Adoption.

2. CHANGE ADDRESS From \_\_\_\_\_ To \_\_\_\_\_

Phone # \_\_\_\_\_

List contracts to be changed # \_\_\_\_\_ # \_\_\_\_\_ # \_\_\_\_\_ # \_\_\_\_\_

3. DIVIDENDS  Change my option for future dividends to  Cash  Reduce Premium  Accumulate at Interest  Paid-up Additions  
 Surrender ( all or \$ \_\_\_\_\_) of dividends on deposit.  
 Apply \$ \_\_\_\_\_ to ( premium or  loan) on contract # \_\_\_\_\_ and send the remainder to me.

4. NON-FORFEITURE Revoke any election heretofore made with reference to the automatic premium loan provision and change my contract to  
 Reduced Paid Up Insurance of \$ \_\_\_\_\_ Effective \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Month) (Day) (Year)  
 Extended Term Insurance \$ \_\_\_\_\_ Effective \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Month) (Day) (Year)  
Cancel all supplementary benefits in accordance with the contract

5. BENEFITS & RIDERS (Complete No. 8 for additions)
- |                          |   |                          |  |
|--------------------------|---|--------------------------|--|
| Add                      | Remove  | Add                      | Remove   |
| <input type="checkbox"/> | <input type="checkbox"/> Accidental Death Benefit           | <input type="checkbox"/> | <input type="checkbox"/> Increasing Term Benefit |
| <input type="checkbox"/> | <input type="checkbox"/> Insured Waiver of Premium          | <input type="checkbox"/> | <input type="checkbox"/> Family Income Benefit   |
| <input type="checkbox"/> | <input type="checkbox"/> Payor Death Benefit Only           | <input type="checkbox"/> | <input type="checkbox"/> Level Term Benefit      |
| <input type="checkbox"/> | <input type="checkbox"/> Payor Death and Disability Benefit | <input type="checkbox"/> | <input type="checkbox"/> Children's Term Rider   |
|                          |   | <input type="checkbox"/> | <input type="checkbox"/> _____                   |

6. CONVERSION OR CHANGE Plan to \_\_\_\_\_ Face amount to \$ \_\_\_\_\_  
Effective date \_\_\_\_\_ Premium mode \_\_\_\_\_ Dividend Option \_\_\_\_\_  
Automatic Premium Loan  Yes  No Planned Periodic Premium (Universal Life Only) \$ \_\_\_\_\_  
Indicate all BENEFITS AND RIDERS to be added or retained. Complete No. 8 if increasing the amount of risk or changing to a lower premium plan. \_\_\_\_\_

PLEASE SUBMIT BENEFICIARY FORM L-5514 WITH ALL CONVERSIONS

7. OTHER

The undersigned understands and agrees as follows: (a) that the statements and answers on both sides of this amendment have been read and whether written by me or not are true and complete to the best of my knowledge and belief; (b) that any change(s) requested herein shall be subject to the provisions and conditions of the contract and that this amendment shall constitute a supplement to the original application / enrollment form for insurance, both of which applications / enrollment forms shall form part of the contract; and (c) that the changes and/or additional benefits requested shall not be effective until this amendment has been approved by the Home Office and any premium, if required, has been paid.

Agent \_\_\_\_\_ Agent Code # \_\_\_\_\_ Date \_\_\_\_\_

Insured \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

Owner, Applicant, or Enrollee (If other than Insured) \_\_\_\_\_ Date \_\_\_\_\_

Beneficiary (If irrevocable) \_\_\_\_\_ Date \_\_\_\_\_



# Federal Life Insurance Company (Mutual)

3750 West Deerfield Road · Riverwoods, Illinois 60015-3598

## Fair Credit Reporting Act

### NOTICE TO APPLICANT/ENROLLEE:

Federal law requires that notice of investigation be given to persons applying or enrolling for insurance.

In making this application/enrollment for insurance to Federal Life Insurance Company (Mutual), it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request to the Home Office of The Company within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation. (See Notice to Applicant/Enrollee – regarding Medical Information Bureau.)

### Notice Of Information Practices – To our Contractholders, Applicants/Enrollees and Insureds

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on the information provided by you. We may also seek information from others, such as medical professionals who have treated you or family members covered under such insurance.

You have the right to be told about, and to see and copy if you wish, items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

The above is a general description of The Company's and its agents' information practices. If you would like to receive a more detailed explanation of those practices, please contact:

Policyholder Services	Federal Life Insurance Company (Mutual)
	3750 West Deerfield Road
	Riverwoods, Illinois 60015

## Medical Information Bureau

### Notice To Applicant/Enrollee:

Information regarding your insurability will be treated as confidential. Federal Life Insurance Company (Mutual) or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its Members. If you apply to or enroll with another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in the MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Federal Life Insurance Company (Mutual) or its reinsurers may also release information in its file to other insurance companies to whom you may apply/enroll for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained at its website [www.mib.com](http://www.mib.com).