Individual Change Form

CLEAR DATA

ADVANCE Insurance Company of Kansas SM

Please retain a copy for the insured.

Advance Insurance Company of Kansas (AICK) is requested to make the following changes in connection with my insurance under:

Subscriber ID _____

Section 1 – Insured Information (always complete this section)

First Name _____ MI _____ Social Security Number _____-_____-_____

Last Name _____ Suffix _____

Section 2 – Change of name for insured

Change insured's name to:

First Name _____ MI _____

Last Name _____ Suffix _____

Reason for change:

☐ Marriage ☐ Divorce _____ /_____ /_____ Date of Change

☐ Other _____ Explain

Section 3 – Change of address for insured

Change address to:

Street Address or PO Box _____

City _____

State _____ ZIP Code _____

Section 4A – Change of primary beneficiary

Only the insured may change the beneficiary. The change of beneficiary must be received prior to the insured's death and will be effective as of the date it is received by AICK's home office.

Primary beneficiary information (receives the benefit upon death of the insured): The proceeds will be paid in equal shares to the persons shown below unless you state otherwise. If you need more space, attach a separate sheet with complete information. You must sign and date the separate sheet.

First Name _____ MI _____ Relationship to Applicant _____

Last Name _____ Suffix _____ Date of Birth _____ /_____ /_____ or Age _____

First Name _____ MI _____ Relationship to Applicant _____

Last Name _____ Suffix _____ Date of Birth _____ /_____ /_____ or Age _____

First Name _____ MI _____ Relationship to Applicant _____

Last Name _____ Suffix _____ Date of Birth _____ /_____ /_____ or Age _____

Please continue on the next page.

Section 4B – Change of contingent beneficiary (you must also complete Section 4A if you fill out this section)

Contingent beneficiary information (receives the benefit only if the primary beneficiary(ies) listed in Section 4A is/are deceased): If there is more than one contingent beneficiary listed below, the proceeds will be paid in equal shares unless you state otherwise. If you need more space, attach a separate sheet with complete information. You must sign and date the separate sheet.

First Name _____ MI _____ Relationship to Applicant _____

Last Name _____ Suffix _____ Date of Birth _____/_____/_____ or Age _____

First Name _____ MI _____ Relationship to Applicant _____

Last Name _____ Suffix _____ Date of Birth _____/_____/_____ or Age _____

First Name _____ MI _____ Relationship to Applicant _____

Last Name _____ Suffix _____ Date of Birth _____/_____/_____ or Age _____

Section 5 – Benefit change

☐ Remove Dependent Child Rider, effective: _____/_____/_____ Effective Date

☐ Remove Accidental Death & Dismemberment (AD&D) Rider, effective: _____/_____/_____ Effective Date

Section 5B – Authorization for the Release of Protected Health Information

I hereby apply for amendment of my policy as indicated on this form. It is mutually agreed that such change shall not become effective unless and until accepted, and that this request for change will become a part of my original application and will be subject to the terms of the policy.

Your signature required

Insured's Signature _____ Date Signed _____/_____/_____

Print Name _____ Social Security Number _____-_____-_____

Questions? Contact us:

By mail: Advance Insurance Company of Kansas
1133 SW Topeka Blvd.
Topeka, KS 66629-0001

Website: advanceinsurance.com
By phone: In Topeka: 785-273-9804; Toll-free: 1-800-530-5989
By fax: 785-290-0727