

**INDIVIDUAL ASSURANCE COMPANY**

Administrative Office: 2400 West 75th Street, Prairie Village, Kansas 66208-3509 1-800-821-5434

Request for Service

| | | |
|---|---|---|
| POLICY NUMBER | INSURED | OWNER (If other than insured.) |
| CHANGE NAME OF: | <input type="checkbox"/> Insured | <input type="checkbox"/> Owner <input type="checkbox"/> Payer |
| FORMER NAME (Please print.) | NEW NAME (Please print.) | |
| REASON FOR CHANGE (If other than correction, marriage or divorce, please attach copy of legal evidence; if available.) | | |
| <input type="checkbox"/> DUPLICATE POLICY REQUEST | | |
| I hereby declare the original policy has been lost or destroyed. Please issue a duplicate policy if possible or a certificate of insurance. If original policy is located, I promise to return the duplicate to the Company. | | |
| <input type="checkbox"/> CANCELLATION OF POLICY | | |
| <input type="checkbox"/> CHANGE OF ADDRESS (Indicate new address.) | <input type="checkbox"/> CHANGE OF TELEPHONE NUMBER (Indicate new telephone number.) | |
| COMPLETE FOR ABOVE REQUEST | | |
| I direct that any amendment of the policy requested above take effect on the date this request is signed, but without any liability to the Company on account of payment made or action taken by it before this request was acknowledged by the Company. I agree that the Company may waive any policy provision requiring presentation of the policy for endorsement, but it may require such presentation if desired. | | |
| _____ | _____ | |
| Signature of Owner | Date | |
| The undersigned agrees to the above requests and changes: | | |
| _____ | _____ | _____ |
| Signature of Assignee (If any.) | Signature of Owner's Spouse (If resident of community property state.) | Signature of Irrevocable Beneficiary (If any.) |