



United Home Life Insurance Company
 225 South East Street, P.O. Box 7192, Indianapolis, Indiana 46207-7192
 Phone: 1-800-428-3001 Fax: 317-692-7711

REQUEST FOR POLICY VALUES OR POLICY CHANGE

Agent's Code _____

Insured _____ Policy No. _____

TAXABLE POLICY DISTRIBUTIONS/CHANGES

- | | |
|--|---|
| <input type="checkbox"/> Policy Loan \$ _____ | <input type="checkbox"/> Place on Settlement Option |
| <input type="checkbox"/> Withdraw Dividends _____ | <input type="checkbox"/> Cash Surrender |
| <input type="checkbox"/> Reduce Policy Face Amount to _____ | <input type="checkbox"/> Surrender of Paid Up Additions |
| | <input type="checkbox"/> Surrender of Paid Up Rider |
| <input type="checkbox"/> Change Dividend Option to: _____ | |
| <input type="checkbox"/> Remove or Reduce the following Benefits or Riders _____ | |
| <input type="checkbox"/> Exercise Non Forfeiture Option (In accordance with policy provisions) | |
| In lieu of additional premium payments, I request the following Non Forfeiture Option: | |
| <input type="checkbox"/> Extended Term <input type="checkbox"/> Reduced Paid Up (Extinguishing Loan) <input type="checkbox"/> Reduced Paid Up (Keeping Loan) | |

THE ABOVE TRANSACTIONS REQUIRE COMPLETION OF THE FOLLOWING:

In accordance with the provisions of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982

- I **DO NOT** want Federal Income Tax withheld from my distribution.
 If you elect not to have Federal Income Tax withheld, you are responsible for payment of any tax due on the taxable portion of your distribution. You may also be subject to tax penalties under the estimated tax payment rules if your payments of estimated tax and withholding, if any, are not adequate. Such distribution is taxable in the year payment is made.
- I elect to have Federal Income Tax withheld according to the applicable withholding provisions of the Tax Equity and Fiscal Responsibility Act of 1982.

I (we) certify that no other person, firm, or corporation has any interest in this policy except the undersigned and that no proceedings in bankruptcy or insolvency have been instituted or are pending against the undersigned. In the event the cash or loan stated in said policy is less than the amount of loan applied for, the Company is authorized to reduce the loan applied for to a sum not exceeding the cash or loan value. I (we) further certify that if this is a surrender of a qualified annuity, I understand the penalties of such a surrender and that I may apply the cash surrender value of this policy to another tax-sheltered plan within 60 days without tax penalty.

I, the policy owner, hereby certify under penalties of perjury, that the Social Security number provided is true, correct, and complete.

OTHER POLICY CHANGES

- Address change or any other request: _____

- Certificate of Insurance is needed as the insured is unable to locate their original policy.
- Change Mode Premium: _____
- Request for Non Smoker/Non-Tobacco Discount

In consideration and forming a part of my policy designated above, and for the express purpose of inducing the company to reissue the policy on a non smoker (or non-tobacco) rating, I hereby represent the following to be true (select one of the following):

- Have you used tobacco in any form in the past 12 months? yes no
- If "yes", indicate cigarettes cigars pipe chewing snuff
- Used tobacco in any form in the past and quit? yes no
- If "yes", date last used? _____

BENEFICIARY CHANGES

IMPORTANT: We suggest that you review **all** previous beneficiary designations each time a change is made in **any** beneficiary. If one of the designations on this form is left blank, any previously named beneficiary of that type (either primary or secondary) will not be changed. Our acceptance of a beneficiary change in no way implies that the change is in compliance with any rule, regulation, law or court order, including but not limited to ERISA requirements, and the Company disclaims any responsibility for the propriety of the change.

Request to Change Beneficiary on Policy _____ Insured _____

This change applies to the base policy and any term riders covering the NAMED INSURED only. (Death proceeds will be payable to joint beneficiaries equally with rights of survivorship unless stated otherwise.)

Social Security Number: _____

Primary Beneficiary: _____

Relationship: _____

Contingent Beneficiary: _____

Social Security Number: _____

Relationship: _____

Request for Name Change (THIS IS NOT AN OWNERSHIP CHANGE)

Please change the name of the Insured Policyowner

From: _____ To: _____

Reason for name change: _____

HOME OFFICE USE ONLY

The foregoing request accepted on _____ , _____ , _____ .
Month Day Year

By Secretary *Lynn B. Jongleux* _____
Authorized Company Representative

RELEASE OF INTEREST

a. By: Collateral Assignee Other (Specify) _____

For the value received, I hereby release all rights, title, and interest in the above policy.

b. SPOUSE/FORMER SPOUSE IN COMMUNITY PROPERTY STATE

I (print full name) _____ , spouse/former spouse of the owner of the above policy, hereby release all rights, title and interest which I may have in this policy now or in the future, by virtue of the Community Property Laws of the State of _____ .

Signature (of Assignee, Spouse/Former Spouse, Other)

Date

Designate Relationship

ANY CHANGE TO INSURED'S ADDRESS WILL AUTOMATICALLY CHANGE OWNER'S ADDRESS UNLESS OTHERWISE NOTED.

ANY ASSIGNEE OR IRREVOCABLE BENEFICIARY WILL ALSO NEED TO SIGN BELOW!

DO NOT SIGN A BLANK FORM

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Foreign Citizenship of Owner/Insured requires an IRS Form W-8 BEN unless holder of Green Card or E-2 Visa.

Owner's Address

City/State Zip

X _____
Owner's Signature

X _____
Owner's Social Security No. (TIN)

X _____
Signature of Agent or Witness

Date

Assignee/Irrevocable Beneficiary