





United Home Life Insurance Company
225 South East Street, P.O. Box 7192
Indianapolis, Indiana 46207-7192
Phone: 800-428-3001 Fax: 317-692-8402

Request for Policy Changes

Insured \_\_\_\_\_ Policy No. \_\_\_\_\_

- Reduce Policy Face Amount to
Change Dividend Option to:
Remove or Reduce the following Benefits or Riders

- Exercise Non Forfeiture Option (In accordance with policy provisions)
Request for Non Smoker/Non-Tobacco Discount (Insured signature required below)

In consideration and forming a part of the 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):

Has the Insured used nicotine in any form in the past 12 months?
If "yes", indicate
Used nicotine in any form in the past and quit?
If "yes", date last used?

- Other Request:
Change Premium Mode: Direct Monthly, Direct Quarterly, Direct Semi Annual, Direct Annual, EFT

If any requests above are marked, then the signature section must be completed at the bottom of this page.

THE FOLLOWING SECTION MUST BE COMPLETED FOR TAXABLE POLICY CHANGES

I, the policy owner, hereby certify under penalties of perjury, that the Social Security number provided below is true, correct, and complete. (Failure to do so will result in Backup Withholding.)

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.
I elect to have Federal Income Tax withheld according to the applicable withholding provisions of the Tax Equity and Fiscal Responsibility Act of 1982.

IF NO ELECTION IS MADE AND IF THERE IS A TAXABLE DISTRIBUTION, THE DEFAULT WILL BE NOT TO WITHHOLD FEDERAL INCOME TAX

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.

RELEASE OF INTEREST: Required Completion if the owner lives in a 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 (Spouse/Former Spouse)

Designate Relationship

Date

ANY ASSIGNEE OR IRREVOCABLE BENEFICIARY WILL NEED TO SIGN BELOW

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

California Residents: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

X Signature of Owner
Owner's Social Security No. (TIN)
Owner's Address
Owner's City/State/Zip Code

X Signature of Witness
X Signature of Insured (Required for Nonsmoker/Nontobacco Request)
X Assignee/Irrevocable Beneficiary
Date

DO NOT SIGN OR WITNESS A BLANK FORM

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HOME OFFICE USE ONLY

The foregoing request accepted on \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_
Month Day Year

By Secretary

[Handwritten Signature]

Authorized Company Representative