INVESTORS HERITAGE *Life Insurance Company*
P.O. Box 717
Frankfort KY 40602-0717

1-800-422-2011
E-Mail: Ihlic@ihlic.com
Web Site: www.ihlic.com

RESET FORM

REQUEST FOR CHANGE

INSURED'S FULL NAME: **POLICY NO:**

OWNER'S NAME:

ADDRESS (IF CHANGED) :

PHONE NUMBER(S) OR EMAIL ADDRESS :

PLACE "X" IN BLOCKS FOR DESIRED CHANGE FOLLOW ANY DIRECTIONS.
SIGN AND DATE AT BOTTOM OF FORM

NOTICE: THIS FORM CANNOT BE USED FOR THE FOLLOWING CHANGES. PLEASE VISIT OUR WEBSITE OR CONTACT OUR HOME OFFICE FOR:

1. Name change Form (Insured, Beneficiary or Owner)
2. Beneficiary Change Form
3. Correction of age Form
4. Ownership change Form

☐ **LOST POLICY OR GROUP CERTIFICATE**

☐ **REQUEST FOR SUMMARY CERTIFICATE:** I certify that the original policy/group certificate numbered above has been lost or destroyed, that a diligent search has been made and that its existence or whereabouts is unknown. In consideration of the granting of this request, I undertake and agree as follows: (1) that the Summary Certificate issued in accordance with this request shall stand in the place and stead of the original policy/group certificate for all purposes; (2) that all of the terms and conditions of the original policy/group certificate shall remain in force and effect as evidenced by this Summary Certificate; that I will save the Company harmless from all loss or injury which may occur as a direct or indirect result of its act of issuing this Summary Certificate; and that if the original policy/group certificate is found, it shall be placed with this Summary Certificate.

☐ **REQUEST FOR COMPLETE DUPLICATE OF POLICY OR GROUP CERTIFICATE ($35.00 Fee):** I certify that the original policy/group certificate numbered above has been lost or destroyed, that a diligent search has been made and that its existence or whereabouts is unknown.

☐ **CHANGE MODE OF PREMIUM PAYMENT:** ☐ ANNUAL ☐ SEMI-ANNUAL ☐ QUARTERLY ☐ MONTHLY *(if available)* ☐ PAYROLL DEDUCTION *(Attach new payroll card)* ☐ PAC *(Attach new PAT card and voided check)*

AMOUNT OF NEW PREMIUM: $ _____

☐ **CHANGE NAME AND ADDRESS OF PERSON RECEIVING PREMIUM BILLING:**

Name: _____
Address _____
City, State, Zip: _____

☐ **CHANGE PLAN OF INSURANCE OR AMOUNT OF INSURANCE:** ***(Return Policy for Endorsement)***

☐ From Plan: _____ To Plan: _____

☐ From Amount: $ _____ To Amount: $ _____ Premium: $ _____

☐ **TERM CONVERSION**
☐ **GIO OPTION**
(Please complete ALL questions)

PLAN NAME: _____ **VOLUME:** _____
PREMIUM: $ _____

BENEFICIARY: _____ Relationship: _____

PREMIUM PAYMENT MODE:

☐ ANNUAL ☐ SEMI-ANNUAL ☐ QUARTERLY ☐ MONTHLY *(if available)* ☐ PAT-(Attach new PAT card and voided check)
☐ PAYROLL DEDUCTION (attach new payroll card)

☐ **OTHER REQUESTS:**

DATE: _____ _____
Signature of **Owner of Policy** (Always Required)

WITNESS: _____ _____
(If agent include Agent Number) Assignee Signature if applicable