

POLICY CHANGE FORM

Date: _____ Policy No.: _____

Insured: _____ Owner: _____

Mailing Address: _____
Street City Province Postal Code

Telephone (Residence): _____ Telephone (Business): _____

We want to serve you efficiently and quickly. Please complete the appropriate areas, sign, date, have your signature witnessed and return to us.

1. Request for Change of Beneficiary (Give complete names as Jo Anne Jones not Mrs. John Jones.) Revocable
Change Primary Beneficiary to: (and indicate Date of Birth and relationship to insured.) Irrevocable

Name: _____ Date of Birth: _____ Relationship to insured: _____

Name: _____ Date of Birth: _____ Relationship to insured: _____

If more than one beneficiary is named, then in equal shares to the survivors, unless otherwise indicated.

If there is no survivor, then to the contingent beneficiary.

A beneficiary designation is Revocable unless designated Irrevocable (except in Quebec where a Designation in favour of Spouse is Irrevocable unless designated Revocable).

Trusts: (Include appropriate documents)

Change Contingent (Secondary) Beneficiary to:

Name: _____ Date of Birth: _____ Relationship to insured: _____

Name: _____ Date of Birth: _____ Relationship to insured: _____

If more than one contingent beneficiary is named, then in equal shares to the survivors, unless otherwise indicated.

Signature of irrevocable beneficiary (required): _____ **Date:** _____

2. Request for Change of Policy Owner

Change owner to: _____ Relationship to insured: _____

Address: _____
Street City Province Postal Code

Signature of new owner: _____ Social Insurance No.: _____

Signature of irrevocable beneficiary (required): _____ **Date:** _____

The beneficiary designation will be changed to estate of the new owner unless the beneficiary change section above, is completed.

3. Change Name of Insured Owner Payor

From: _____ To: _____
(Print old name in full) (Print new name in full)

Reason for change: _____ New Signature: _____

Attach supporting documents (ie. Marriage Certificate)

4. Change Mode of Premium Payment to:

Annual Semi-Annual Pre-Authorized Monthly (Send sample cheque marked VOID.)

Please note—This form must be signed by the person(s) indicated and returned to us.

Insured/Owner: _____ Witness: _____
Old Signature if Change Of Name Non Relative

Address (Insured/Owner): _____
Street City Province Postal Code

Dated at _____ this _____ day of _____, 20_____.

Agent's name: _____ Agent's Number: _____

Registered at the Head Office of Penncorp Life Insurance Company. Penncorp Life Insurance Company assumes no responsibility for the validity or sufficiency of the designation/assignment.

For Head Office
Use Only

Recorded by _____ Title _____ Date _____