

SERVICE REQUEST FORM

Instructions
 1. Multiple changes to the same policy may be requested on this form.
 2. Signatures must be in ink. Record the place and date. The signatures must be witnessed by a third party.

Name of Insured _____ <small style="display: inline-block; width: 200px; text-align: center;">Last name First name Middle Initial</small>	Employer Name _____
--	---------------------

Date of Birth _____	SSN: _____	Policy No. _____
---------------------	------------	------------------

I. Change of Insured's Name

From _____ To _____

Reason: Marriage, Divorce, Other (explain) _____

Date of Change _____

II. Change of Insured's Address

Current Address:	Number & Street _____
	City _____ State _____ Zip _____

New Address:	Number & Street _____
	City _____ State _____ Zip _____

III. Request for Duplicate Policy

To the best of my knowledge and belief, the above numbered policy has been lost or destroyed. I hereby request that a duplicate policy be issued.

IV. Beneficiary Designation:

Primary Beneficiary(ies)	Full Name(s)	D.O.B.	Relationship(s)
Contingent Beneficiary(ies)	Full Name(s)	D.O.B.	Relationship(s)

V. Other Requests

Please sign below:

_____ Signature of Insured	_____ Signature of Witness
Signed at _____ on _____	_____
<small>City State Date</small>	

**Return completed form to: Administrative Services, 300 Southborough Dr. Ste. 200
 South Portland, ME 04106-6914 Phone: 1-800-877-2701 Fax: 1-877-820-5311**