Affiliates:
Annuity Investors Life Insurance Company®
Manhattan National Life Insurance Company

Administrator for Life Insurance and Annuities:
Cigna National Health Insurance Company
Continental General Insurance Company®
Loyal American Life Insurance Company®
Provident American Life & Health Insurance Company

PO Box 5416, Cincinnati OH 45201 / 888-863-5891 / 800-859-0021 Fax
Overnight Address: 191 Rosa Parks St, Cincinnati OH 45202

LIFE POLICY CHANGE REQUEST

1. OWNER/INSURED INFORMATION (Must be completed for all requests - Please print)

Owner(s)	Policy number
Social Security or Tax ID Number(s) of Owner	Daytime Phone ( )
Address	
Insured's Name if other than the owner	

2. NAME CHANGE

Proof of the name change **is required** in addition to this form. Please attach to your request a copy of your marriage certificate, a divorce decree (specifically stating that your name is changed), or other court order changing your name.

Change the name of: ☐ INSURED ☐ OWNER ☐ OTHER (SPECIFY) ___________________________

Former Name: ______________________ ______________________
Please Print Please Sign (Old Name)

Present Name: ______________________ ______________________
Please Print Please Sign (New Name)

3. ADDRESS CHANGE (Please print)

Change the address of: ☐ INSURED ☐ OWNER ☐ OTHER (SPECIFY) ___________________________

New Address ______________________ Daytime Phone ______________________

City/State/Zip ______________________ Evening Phone ______________________

4. POLICY CHANGES

☐ Reduce Death benefit: (Specify amount to be reduced to) ______________________

☐ Terminate Rider: (Specify Rider to be terminated)______________________

☐ Whole Life Conversion:(Specify benefit Amount)______________________

☐ Scheduled Premium Change: (Universal Life Policies Only)
Premium $______________________ Frequency: ______________________

5. BENEFICIARY CHANGE (Please print)

If this section is completed, I/we hereby revoke all prior designations of Beneficiaries and make the following new Beneficiary designation, subject to the provisions of the policy, and subject to the rights of any assignee of record with the appropriate Company.

With respect to any trust designated as Beneficiary, the appropriate Company shall neither be obligated to inquire into the terms of the trust, nor shall the appropriate Company be chargeable with knowledge of the terms of the trust, and the appropriate Company will be fully discharged from all liability after payment of the Death Benefit proceeds under the policy to the trustee. ***If the owner of the policy is a trust, we may reject the designation of any Beneficiary other than the trust itself.***

The Death Benefit will be paid to the primary beneficiaries or survivors of them in equal shares unless otherwise stated. The Death Benefit will be paid to contingent beneficiaries or survivors of them in equal shares unless specified otherwise and only if there are no surviving primary beneficiaries. If percentages are specified, they must total 100% for Primary and 100% for Contingent, if any. **If the Beneficiary listed below is not designated as a primary or contingent Beneficiary, it will automatically default to a primary designation. If no primary Beneficiary is designated below, the contingent Beneficiary will be treated as the primary.**

Please show full name, address, relationship to the Owner(s), date of birth, and social security number of all beneficiaries. A failure to do so may result in the death benefit being escheated to the state. If the Beneficiary is a trust, please provide the trust's name, the trustee name(s), and the trust agreement date.

If additional space is needed, attach a separate sheet signed and dated by the owner(s).

Beneficiary(ies) Type: ☐ Primary ☐ Contingent Percentage: ____________ %	
Name	Relationship
Social Security # / Date of Birth / Phone # / Email Address	
Address	

Beneficiary(ies) Type: ☐ Primary ☐ Contingent Percentage: ____________ %	
Name	Relationship
Social Security # / Date of Birth / Phone # / Email Address	
Address	

Beneficiary(ies) Type: ☐ Primary ☐ Contingent Percentage: ____________ %	
Name	Relationship
Social Security # / Date of Birth / Phone # / Email Address	
Address	

Beneficiary(ies) Type: ☐ Primary ☐ Contingent Percentage: ____________ %	
Name	Relationship
Social Security # / Date of Birth / Phone # / Email Address	
Address	

6. SIGNATURE AUTHORIZATION OF OWNER(S) (This Section **MUST** be completed for all changes.)

By signing this form, each Owner agrees and certifies that the appropriate Company is authorized to make the changes to the policy as indicated on this form, and further agrees to hold harmless and indemnify that Company as to any and all claims or demands which may be made by reason of the changes so made.

Signature of Owner (If Corporation, signature and title of authorized officer)	Date	Signature of Joint Owner (If Applicable)	Date

IMPORTANT NOTES:

- **We reserve the right to require that the signature(s) of the Owner(s) be notarized. To avoid processing delays, please consider having your signature notarized prior to submitting this request.**
- If a Power of Attorney is used to sign this form, then we must have received a copy of the Power of Attorney document. We will also require a completed Affidavit Related to Power of Attorney, Form #AAG2816, signed within 90 days of the change request. Unless the Power of Attorney expressly authorizes you to designate a beneficiary, then our acceptance of a Beneficiary designation will be conditioned on receiving the consent of all interested parties before a death benefit is paid.
- For policies owned by a Trust, the acting Trustee(s) must sign. In addition, if there has been a change of Trustee(s) from the Trustee(s) on file, then either a new trust certification form (#X6017907NW) or trust pages showing the Successor trustee(s) together with documentation of the resignation, removal, incapacity, or death of the prior trustee(s) must be submitted.

STATE OF ____________________)
) SS:
COUNTY OF ____________________)

Acknowledged before me this day of in the year

by

My Commission expires:

____
MM/DD/YYYY

____
Signature of Notary Public

SEAL