MEDICARE SUPPLEMENT POLICYOWNER SERVICE REQUEST

Family Life Insurance Company

Insured's Information (All information in this section must be completed)	
Insured's Last Name	Insured's First Name
Policy Number	Social Security Number
Insured's Address (Street, City, State, ZIP Code)	
Daytime Telephone Number of Owner Between 8am-4pm CST	

Please check the Box beside the change you wish to make and complete the requested information.

1. Name Change ❑	
Former Name (Please Print)	New Name (Please Print)
Reason for Name Change *	Date of Change

* Please provide a copy of legal evidence of the name change (for example, a marriage certificate or a divorce decree)

2. Premium Mode Change ❑			
Please change my payment mode to the following:			
Monthly EFT ❑	Quarterly Direct ❑	Semi Annual Direct ❑	Annual Direct ❑
	Quarterly EFT ❑	Semi Annual EFT ❑	Annual EFT ❑

3. Address Change ❑
Former Address (Street, City, ST, ZIP Code)
New Address (Street, City, ST, ZIP Code)

Remarks or Special Instructions:

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______________________________ **Policyowner's Signature**

______________________________ **Date**

Mail Completed Form To:
Family Life Insurance Company
10777 Northwest Freeway
Houston, TX 77092

Customer Service Department: 1-800-877-7703
www.familylifeins.com

ManhattanLife™

FLIC-POL-SERV-0509