



# Health Policyholder Request Letter

## Routine Policy Changes

Policy No.(s) \_\_\_\_\_ Principal Insured's Name \_\_\_\_\_

Change Address \_\_\_\_\_  
Street City State ZIP Code

Check Appropriate Box:  Permanent  911 change  Ownership change  
 Temporary  Mailing only change  
Within City Limits  Yes  No

Addition or Correction of Social Security Number to: \_\_\_\_\_

ID Card Request  Duplicate Policy Request

Change Payment Mode to:  
 Quarterly  
 Semi-Annual  
 Annual  
 State Farm Payment Plan (SFPP) Account # \_\_\_\_\_ . (NOTE: Contact your State Farm Agent for all new SFPP accounts or any additions to an existing SFPP account.)

Effective Date \_\_\_\_\_

Increase Deductible: Amount \$ \_\_\_\_\_ Effective Date \_\_\_\_\_

Change Name to: New Name \_\_\_\_\_ Effective Date \_\_\_\_\_

Remove Insured: Name \_\_\_\_\_ Effective Date \_\_\_\_\_  
Reason \_\_\_\_\_

Add Newborn: Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(NOTE: If over 62 days since date of birth - contact your State Farm Agent to submit a fully completed application.)

This section applies to Individual Credit Disability Insurance, Long-Term Care Insurance, and Mortgage Disability Income Insurance policies.

### Assignment/Third Party Billing:

Add or Change Name and/or Address to: \_\_\_\_\_  Delete Assignment/Third Party Billing

If Individual Credit Disability Insurance, has the loan been paid off?  Yes  No Effective Date \_\_\_\_\_  
(NOTE: If yes, date and copy of termination are required.)

Add Non-Tobacco Discount: Provide the Month/Year tobacco, or any other nicotine product, was last used \_\_\_\_\_

This section applies to Disability Income Insurance, Long-Term Care Insurance, and Mortgage Disability Income policies:

Increase Elimination Period to \_\_\_\_\_ days      Effective Date \_\_\_\_\_

Decrease Daily Benefit to \_\_\_\_\_      Effective Date \_\_\_\_\_

Decrease Benefit Period to \_\_\_\_\_      Effective Date \_\_\_\_\_

Change/Remove Rider \_\_\_\_\_

*(NOTE: Specify Rider. It is important you understand the consequences of this change, especially for Long-Term Care Insurance. Increases in coverage require contacting your State Farm Agent to submit a fully completed application.)*

Effective Date \_\_\_\_\_

Change to a less hazardous/manually intensive occupation:

Start date of new occupation: \_\_\_\_\_

New occupation title:

\_\_\_\_\_

Details of occupational duties:

\_\_\_\_\_

*(NOTE: Policyholder must be employed 6 months at the new occupation and plans to continue in this new occupation. If a change can be made in the occupation class rating, the premium adjustment will become effective on the next renewal after notification of the occupation class change.)*

This section only applies to Hospital Income Insurance policies.

Change Ownership to:

\_\_\_\_\_  
New Owner's Name

\_\_\_\_\_  
New Owner's Address

\_\_\_\_\_  
New owner's Signature

\_\_\_\_\_  
Date

Cancel Policy: Reason \_\_\_\_\_ Effective Date \_\_\_\_\_

Remarks:

\_\_\_\_\_

\_\_\_\_\_  
Signature of Policyowner

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Agent's Name