Allstate Benefits

American Heritage Life Insurance Company
Allstate Benefits
1776 American Heritage Life Drive
Jacksonville, Florida 32224

Please mail or fax completed & signed form to: The MPM Group, LLC
1010 Monarch Street, Suite 220
Lexington, KY 40513
Fax: (859) 224-1288

Health Policy Service Request

Policy/Certificate Number(s) ____________________ **Policy Owner's Name** ____________________

Insured's Name if different than Owner ____

Policy Owner Mailing Address ____
(Street) (Apt)

____ ❑ ***Check if this is a new address***
(City) (State) (Zip)

Email ______________________________
By providing your email address, you agree that we may email you a customer satisfaction survey to obtain feedback about this transaction.

Section 1: Name, SSN, Ownership, Date of Birth

1.❑ Name and Social Security Number Change Request, Date of Birth correction

❑ **Correct or add Social Security Number for** (name of individual) ____________________

Social Security Number____________________ (❑ owner, ❑ insured or ❑ dependent)

❑ **Change Name Of** ❑ Insured ❑ Dependent ❑ Owner ❑ Payor

From: ____

To: ____

Reason for name change: ❑ Marriage ❑ Divorce ❑ Legal Name Change *(Provide Legal Documents)*

❑ Misspelled Name Correction ❑ Other (specify) ____________________

❑ **Date of Birth correction** ______________________________ *(Provide Legal Documents)*

2.❑ Change of Ownership
(This option is to change from current owner to a new owner as contractually accepted, Accident AP1 – AP6)

____
(New Owner's full name) (Relationship to Primary Insured)

____
(Street) (Apt) (City) (State) (Zip)

____
(Date of Birth) (New Owner's Social Security Number)

____
(Contact Phone Number) (Email)

❑ **Please check here if change of ownership is due to the death of the current owner**
(Provide certified Death Certificate)

Section 2: Reduction, Removals, Primary Insured, Newborn Child

1.❑ Coverage Changes, Reductions or Removals

❑ Change from Family to ❑ Individual Coverage ❑ Individual and Spouse Coverage
❑ Individual and Child coverage
❑ Reduce the amount of insurance Basic Policy From: ______________ To: ______________
❑ Reduce the number of Rider Units From number of Units: ______________ To number of Units: ______________
Rider Name ______________
❑ Remove the following Benefit Rider(s) ______________________________

2.❑ Change of Primary Insured *(only due to death of current Primary Insured)*

❑ Name of New Insured ____________________
Social Security Number____________________ Date of Birth ____________________
Gender ______________ Date of Death ____________________
(Provide copy of Death Certificate)

3.❑ Newborn Child

❑ Add Newborn child (if no underwriting required; born after effective date of in-force **Family** or **Individual and Child** coverage)
Name of Newborn ______________________________
Gender ______________ Date of Birth ____________________
Relationship of Dependent to Primary Insured ______________________________

Section 3: Correspondence, Duplicate Policy

1. ❑ Application for Duplicate Policy or Certificate	I certify that the above policy has been lost or destroyed and that said policy is not assigned, hypothecated, or pledged in any way whatsoever. I, therefore, request the issuance of a duplicate of said policy and agree that should the original policy be found or in any way come into my possession, I will return or cause the same to be returned to American Heritage Life Insurance Company, its successors or assigns. It is distinctly understood and agreed that the original policy shall become null and void immediately upon issuance of the duplicate policy herein requested. I also agree that if duplicate forms of the lost policy are not available, I will accept a Certificate of Lost Policy.
2. ❑ Other Instructions (Please be specific. For example: Separation from employer on X/X/XX, please change to direct bill)	

I agree that my signature below shall apply to each request which has been checked on this form. I further agree that only checked items will be considered for processing. (Date and signature required below)

➡ **Policy Owner's Signature Required for all Requests** ______________________ **Date** ______________

Agent Name and Producer Number ____

Note: For Corporate Owner, provide corporation name, two officer's signatures and their titles.

____________________	____________________	____________________
Company Name	Officer Signature/Title	Officer Signature/Title