

CHANGES AND CANCELLATIONS:

CANCELLATIONS

Please note that all cancellations must be received in writing by SBS no later than the 15th of the month to be effective the first of the following month. You may fax your cancellations to SBS at 614-793-8663.

You can write your cancellation in the “Other Instructions Section” of the Policyholder Service Form below .

If a cancellation is not received in writing or is received later than the 15th of the month the deduction will still come out of the paycheck.

CHANGES TO AN EXISTING POLICY

If you need to make changes to your policy you can complete the following Policyholder Service Form and complete the appropriate section. This form must be received by SBS by the 15th of the month to have the change be effective for the first of the following month



Allstate

Workplace Division

Policyholder's Change and Service Request

For American Heritage Life Insurance Company (Home Office: Jacksonville, FL)

Notice to Policyholder: Funds released when borrowing, surrendering, or withdrawing any policy values may affect the guaranteed elements, non-guaranteed elements, face amount or surrender value of the policy.

Policy Number (use separate form per policy)	Name of Insured (Last, First, Middle)	Agent Name and Number (Please Print)
Take the following action(s) regarding this policy subject to AHL's current rules.		
1. <input type="checkbox"/> Policy Changes, Reductions or Removals	<input type="checkbox"/> Change from <i>Family</i> to <i>Individual</i> coverage on health policy due to _____. If due to death of Insured, Name of New Insured _____, SS#, _____ Date of Birth _____. <input type="checkbox"/> Add Newborn child (if no underwriting required) Name of Newborn _____ Date of Birth of Newborn _____. <input type="checkbox"/> Reduce the amount of insurance From _____ To _____ Basic Policy _____ <input type="checkbox"/> Remove the following Benefit Rider _____ <input type="checkbox"/> Change Death Benefit Option from 2 to 1 (if changing from 1 to 2, application must be submitted for underwriting purposes) <input type="checkbox"/> Cancel Life policy when replacement policy is issued (for life policies with no fund value)	
2. <input type="checkbox"/> Annuity or UL Partial Surrender (Withdrawal)	\$ _____ or the maximum allowed by policy, if less. *Under UL Policy, the death and fund value will be reduced by the amount of partial surrender. *Service Fees or surrender charges will be deducted from fund value. Note: Form C-123 also required with this request.	
3. <input type="checkbox"/> Policy Loan	<input type="checkbox"/> \$ _____ in cash. <input type="checkbox"/> For maximum amount available. <input type="checkbox"/> To pay current premium due on policy number(s) _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Automatic Premium Loan. Make the Automatic Premium Loan Provision: <input type="checkbox"/> Operative <input type="checkbox"/> Inoperative This loan plus any other debt owed AHL is a first lien against the policy values. There are no proceedings in bankruptcy pending against any owner signing this form.	
4. <input type="checkbox"/> Dividend Withdrawal	<input type="checkbox"/> \$ _____ in cash. <input type="checkbox"/> For maximum amount available. <input type="checkbox"/> To pay current premium due on policy number(s) _____ <input type="checkbox"/> To apply to loan on policy number _____ <input type="checkbox"/> Other _____	
5. <input type="checkbox"/> Maturity Request	<input type="checkbox"/> I elect option number _____ as stated in my contract. Payments to be made <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually If applicable, payments to be made for a period of _____ Years. <input type="checkbox"/> Change Maturity Date to _____. <input type="checkbox"/> Change Maturity Age to _____. Note: If requesting a maturity option, for C-123 also required.	
6. <input type="checkbox"/> Flexible Premium Payment Changes (FPA or UL only)	<input type="checkbox"/> Place policy in non-billing status <input type="checkbox"/> Place policy back into a premium paying status. <input type="checkbox"/> Change premium to \$ _____ (Per <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual) <input type="checkbox"/> Make change effective _____	
7. <input type="checkbox"/> Change Name of	<input type="checkbox"/> Insured <input type="checkbox"/> Owner <input type="checkbox"/> Payor From _____ To _____ Reason for change _____ (Complete change of Address Form if needed.) Note: If the reason for the change of name is other than marriage, a certified copy of the court order is required.	
8. <input type="checkbox"/> Address Change	Name (Last, First, Middle) Street City State Zip	Other Policy Numbers to be changed

Policy Number (use separate form per policy)	Name of Insured (Last, First, Middle)	Agent Name and Number (Please Print)
Take the following action(s) regarding this policy subject to AHL's current rules.		
9. <input type="checkbox"/> Guaranteed Option Requests	<input type="checkbox"/> Change Automatic Option to (if applicable): <input type="checkbox"/> Reduced Paid-Up <input type="checkbox"/> Extended Term <input type="checkbox"/> Stop Premium and Adjust Coverage to (if applicable): <input type="checkbox"/> Reduced Paid-Up <input type="checkbox"/> Extended Term <small>*supplemental benefits cancel when premiums stop</small>	
10. <input type="checkbox"/> Transfer of ownership to <small>(Do not use for collateral assignment)</small>	All policy ownership rights will vest in the new owner shown below.	
	New Owner (Last, First, Middle)	Soc. Sec. # / F.E.I.N #
	Address (Street, City, State, Zip)	
At the death of the new owner, the successor owner is: <input type="checkbox"/> Insured, or <input type="checkbox"/> _____ <small>*If a change of beneficiary is desired, it must be requested on form B-040, by the new owner. *This transfer is subject to the term of any irrevocable beneficiary designation in effect or any other ownership restrictions.</small>		
11. <input type="checkbox"/> Premium Mode Change to <small>(Direct Bill only)</small>	<input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Pre-authorized Check Plan (PAC) <small>*PAC authorization and voided check required.</small>	
12. <input type="checkbox"/> Payroll Allotment Billing Changes	<input type="checkbox"/> Case No. _____ <input type="checkbox"/> Control No. _____ <input type="checkbox"/> Payor Name _____	
	<input type="checkbox"/> Place policy on Direct Bill <input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Pre-authorized Check Plan (PAC) <small>*PAC authorization and voided check required. *At least one month's premium required. Check for \$ _____ attached.</small>	
13. <input type="checkbox"/> 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 for Lost Policy.	
14. <input type="checkbox"/> Other Instructions <small>(Be specific)</small>		
15. <input type="checkbox"/> Request for Conversion to Individual Policy from Group Coverage <small>(Be Specific)</small>	<input type="checkbox"/> Cancer <input type="checkbox"/> Other Current Billing Address: _____ Employer: _____ Group Policy Number: _____ Certificate Number: _____ What policy do you want to convert to: _____ Application for the converted policy must be made to us within 31 days (within 60 days of final divorce decree in case of divorce) after the coverage terminates. The effective date of the converted policy will be the date on which this coverage terminated.	
Note: For corporate owner, provide corporation's name, two officer's signatures and their titles	Owner _____ Date _____ Owner _____ Date _____ Assignee (if applicable) _____ Date _____	
Agent Use Only – Subject to AHL rules, send all items to be returned to: <input type="checkbox"/> Agent <input type="checkbox"/> Owner		Home Office Use Only – Date Recorded _____ By _____ To Be Effective On _____