Please check the box next to your insurance company's name.

❑ **Central United Life** ❑ **Investors Consolidated** ❑ **Sun America** ❑ **Loyal**
❑ **Gold Cross** ❑ **UniLife** ❑ **Unum** ❑ **American States**

10700 Northwest Freeway, Third Floor, Houston, Texas 77092

HEALTH POLICY CHANGE FORM

THIS SECTION MUST BE COMPLETED FOR ALL CHANGES

Insured's Name: ______________________ If group policy, name of Group: ______________

Policy #: ______________________ Social Security #: ______________________

Insured's Address: ____

City: ______________________ State: ______________ Zip Code: __________

Contact Number(s) Daytime: ______________________ Evening: ______________________

FOR DELETIONS: Upon receipt of this request the Home Office will notify the Insured of any premium adjustments.

IF DELETION, please check this box. ❑

*Person to be deleted: ____

Relationship: ____

*If deletion is due to divorce, a copy of the divorce decree and ex-spouse's current mailing address is required.
*If deletion is due to death, a copy of the death certificate is required.

Date: ______________________ Signature: ______________________

IF NAME, ADDRESS or BENEFICIARY CHANGE, please check this box. ❑

Name Change: ______________________ Date of Birth: ______________

Address Change: ____

Beneficiary Change: ____

Date: ______________________ Signature: ______________________

FOR OFFICE USE ONLY

COMPLETE AND RETURN THIS FORM
Please fold this form and
Return it to the address printed above.

ENDORSEMENT TO POLICY

HPC 0505