HM LIFE INSURANCE COMPANY

HM WORKSITE ADVANTAGE SERVICE REQUEST FORM

Certificate Number	Insured		Owner (*if other than Insured*)		
Home Address	City	State	Zip Code	Phone Number	

1. ☐ CHANGE OF BENEFICIARY *(Witness must be someone other than beneficiary.)*

It is requested that the beneficiary under the above Certificate be changed as follows:

Primary Beneficiary		Relationship to Insured	
Home Address	City	State	Zip Code
Contingent Beneficiary		Relationship to Insured	
Home Address	City	State	Zip Code

2. ☐ CHANGE OF NAME *(Please attach official document of name change.)*

Former Name	New Name
Reason for Change	

3. ☐ CHANGE OF ADDRESS

Former Home Address	City	State	Zip Code
New Home Address	City	State	Zip Code	New Phone Number

4. ☐ TRANSFER OF OWNERSHIP REQUEST

I request that all benefits, rights and privileges incident to ownership of the policy vested in the new Owner named below, or to such new Owner's executors, administrators and assigns, or successors and assigns.

New Owner (Last, First, Middle)		Relationship to Insured	
Address of New Owner	City	State	Zip Code

5. ☐ UNIVERSAL LIFE ONLY – Discontinue Premium Deduction Only/Allow Policy to Continue

I request that all payroll deductions or billings be discontinued at this time. I understand that I must notify HM Life Insurance Company to start payroll deductions or billings at a later date. I understand that my policy will continue to remain inforce until all accumulated value capable of continuing the policy is depleted or until I request continuation of premium payments. I understand that once accumulated value capable of continuing the policy is depleted, the policy will lapse.

6. ☐ LOST CERTIFICATE NOTIFICATION

I, _____, hereby certify that Certificate Number _____, dated _____, and issued by HM Life Insurance Company has been lost or destroyed and that said Certificate is not assigned, hypothecated, or pledged in any way whatsoever. I, therefore, request a Certificate of Lost Certificate and agree that should the original Certificate be found or if any come into my possession, I will return or cause the same to be returned to HM Life Insurance Company, its successors or assigns. It is distinctly understood and agreed that the original Certificate shall become null and void immediately upon issuance of the Certificate herein requested.

7. ☐ CANCELLATION/CHANGE OF COVERAGE

I have reviewed the benefits of the plan and have decided to cancel my coverage. I understand that by waiving my rights to continue my coverage, I may be required to show evidence of insurability to re-qualify for coverage:

☐ **Critical Illness**
☐ Employee ☐ Spouse

☐ **Accident**
☐ Employee ☐ Spouse ☐ Child*

☐ **Traditional Cancer**
☐ Employee ☐ Spouse ☐ Child*

☐ **Disability**

☐ **Supplemental Hospital Indemnity**
☐ Employee ☐ Spouse ☐ Child*

☐ **Universal Life**
☐ Employee ☐ Spouse ☐ Child*

☐ **Other**: _____

☐ **Reduce Face Amount** (applies to Critical Illness, Disability and Universal Life only)

☐ **New Face Amount: Employee**
$_____

☐ **New Face Amount: Spouse**
$_____

*If you have spouse or dependent coverage on the plan(s) that you wish to cancel, please specify if you wish to cancel the entire plan or if you want to cancel only a portion of your plan by checking the appropriate boxes above. If you want to cancel your spouse and/or dependent(s) from the plan, please provide their name(s) and date(s) of birth below *(attach sheets if you need additional space):*

Name	Date of Birth	Name	Date of Birth

8. ☐ LOAN/WITHDRAWAL REQUEST *(Please allow a minimum of 45 days for processing.)*

I request a loan of $ _____, or the maximum amount, if less.

9. ☐ SURRENDER FOR CASH VALUE *(Please allow a minimum of 45 days for processing.)*

Please note: Your Certificate must accompany this request. If unavailable, Section 7 of this form MUST be completed. I request payment of the case value in exchange for surrender of the attached Certificate. No bankruptcy proceedings are outstanding against me and no liens are pending against the Certificate, except as follows:

Sign and date here for above requests.

Signature of Owner				Date
Home Address	City	State	Zip Code	Phone Number
Signature of Witness				Date

Signature of Assignee (*if applicable*)	Signature of Irrevocable Beneficiary (*if applicable*)

Administered by/Mail Completed Form to:
Continental American Insurance Company
P.O. Box 2048
Columbia, South Carolina 29202
(866) 849-2954