

SERFF Tracking Number: STAR-128189466 State: Arkansas
Filing Company: Starmount Life Insurance Company State Tracking Number:
Company Tracking Number:
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Universal Application & Policy Change Form
Project Name/Number: /

Filing at a Glance

Company: Starmount Life Insurance Company

Product Name: Universal Application & Policy Change Form SERFF Tr Num: STAR-128189466 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved- Closed State Tr Num:

Sub-TOI: L08.000 Life - Other

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Belle Lucas, Natka

Disposition Date: 03/27/2012

Varisco, Ruston Woolley

Date Submitted: 03/22/2012

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 03/27/2012

State Status Changed: 03/27/2012

Deemer Date:

Created By: Ruston Woolley

Submitted By: Ruston Woolley

Corresponding Filing Tracking Number:

Filing Description:

Dear Sir/Madam:

We are pleased to file the above referenced application forms in Arkansas. This filing is a new filing and is being filed without an illustration.

The Universal Application is an additional application that will be used with previously approved life products.

The following lists the products used on the Universal Application and their approval dates:

Valuelife Gold (32-001)- approved 12-5-2008

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Starlife Gold (21-001)- approved 12-4-2006
Selectlife (51-001)- approved 8-23-2006

A previous version of this application was approved on 11-03-2011 (STAR-127753216). Changes made to the application include:

- Revised wording of the medical questions.
- Language in the billing section of the application has been revised to be easier understood by the applicant.
- A MIB statement has been added to the authorization section.
- Language in the authorization has been changed to make it easier to understand.
- Agent replacement question has been added to the application.
- New variable items have been added to the Insured's demographic section, payment options, and the questions. All items are fully described in the accompanying statement of variability.

These products will continue to be marketed through individual mailers or through other affinity marketing, such as associations and also through agents as standalone coverage to individuals at the workplace and through the internet. The Universal Application will be placed on our website upon approval.

The Policy Change Form is a revision of our Reinstatement Application that was approved on 10-27-2011 (STAR-127742752). The application has been revised to include additional uses. The form will now provide options to convert their current policy to Starlife Gold (21-001) or Selectlife (51-001), increase the face amount of their policy, or reinstate their cancelled or lapsed policy. All options are bracketed and will be removed from the form if that option is not being offered.

Changes made to the application include:

- Revised wording of the medical questions.
- A MIB statement has been added to the authorization section.
- Language in the authorization has been changed to make it easier to understand.
- New variable items have been added to the Form Options and the Declaration. All items are fully described in the accompanying statement of variability.

Please contact me if you have any questions at 225-400-9247 or by email rustonb@starmountlife.com.

Sincerely,
Ruston Woolley;
Compliance Specialist

Company and Contact

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Filing Contact Information

Ruston Woolley, Compliance Specialist rustonb@starmountlife.com
 8485 Goodwood Blvd. 225-400-9247 [Phone]
 Baton Rouge, LA 70806-7878 225-610-1447 [FAX]

Filing Company Information

Starmount Life Insurance Company CoCode: 68985 State of Domicile: Louisiana
 7800 Office Park Boulevard Group Code: Company Type:
 Baton Rouge, LA 70809 Group Name: State ID Number:
 (225) 926-2888 ext. [Phone] FEIN Number: 72-0977315

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? Yes
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Starmount Life Insurance Company	\$100.00	03/22/2012	57374574

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	03/27/2012	03/27/2012

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Disposition

Disposition Date: 03/27/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	UNVRSL1 Statement of Variability		Yes
Supporting Document	PlcyChg1 Statement of Variability		Yes
Form	UNVRSL1		Yes
Form	PlcyChg1		Yes

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Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	UNVRSL1	Application/UNVRSL1 Enrollment Form	Initial		41.300	UNVRSL1 Reg4.pdf
	PlcyChg1	Application/PlcyChg1 Enrollment Form	Initial		44.200	PlcyChg1 Reg 4.pdf

[**AGENT:** Does the proposed insured have an existing policy or contract, please sign below and list the policy or contract information as requested if you answer Yes. Yes No **Agent's (Producer) Signature:** _____ **Lic. No.:** _____

Please list the name of the insurer, policy or contract number or application number, if you answered Yes above: _____

Agent: Leave with the applicant the original or a copy of written or printed communications used for presentation to the applicant and submit a copy of the replacement notice with the application to the replacing insurer.]

[SPOUSE'S APPLICATION ON BACK]

(For Company Use) STAR I.D.: _____

UNVRS1

RGN 4 SOE

[For Term Life Insurance Policy No. 21-001; For Level Premium Whole Life Insurance Policy No. 51-001; For Modified Whole Life Insurance Policy Form No. 32-001]
[Accidental Death Rider Form No. 97005] [Accelerated Benefit Rider 98-010]

[SPOUSE OR FRIEND'S INFORMATION (if to be insured) Please print.

Name _____ [Social Security #] _____ **Date of Birth(REQUIRED)** ____/____/____
Address _____ City _____ State _____ Zip _____
Sex M F Height (Ft. In.) _____ Weight (Lbs.) _____ Email _____
Home Phone (REQUIRED) (_____) _____ Cell Phone (_____) _____
Are you employed? Yes No (If no, explain) _____ Occupation _____
Doctor or Clinic (Full Name) and location _____ City _____ State _____
Beneficiaries (Full Name) _____ Relationship _____

COVERAGE AMOUNT: \$250,000 \$200,000 \$150,000 \$100,000 \$75,000 \$50,000 \$45,000 \$40,000 \$35,000 \$30,000 \$25,000 \$20,000 \$15,000 \$10,000 \$5,000 \$3,000]

ADD ACCIDENTAL DEATH CASH OPTION FOR: **Triple Benefits** **Double Benefits**

PAYMENT METHOD Annually ([5%, 10%] discount for annual payment) Every 3 months Monthly] [(We recommend annually or every 3 months.)]

Deduct payments from my checking account automatically. (Enclose a VOIDED check.)

Charge payments to: VISA MC Credit Card # [XXXXXXXXXXXXXXXXXXXX] Exp. Date: ____/____

Bill me directly for payments. (There is a \$1 charge per month if direct billing is monthly; all other payment options are free)

PLEASE ANSWER THESE QUESTIONS: (Use additional paper if needed.)

8. Have you smoked, chewed or used tobacco in any form in the last 24 months? Yes No **If yes**, do you smoke more than 2 packs per day? Yes No
9. In the last 5 years, have you been diagnosed with, or treated for any of the following conditions: (Circle each condition and explain yes answers.)
 - a. Cancer; tumor; polyps; stroke; hepatitis; any disease or disorder of the kidneys, heart, blood, liver or circulatory system; any chronic respiratory or lung disorder; or used oxygen to assist in breathing? Yes No
 - b. Mental or nervous disorder; Alzheimer's; dementia; alcoholism; drug addiction; taken illegal drugs; abused prescription medication; been ticketed for DWI or DUI or had a felony conviction? Yes No
 - c. Diabetes Yes No; High blood pressure? Yes No
If yes, are you scheduling regular check-ups and taking medication as prescribed? Yes No
10. Have you ever (in MO, not to exceed 10 years) been positively diagnosed or treated for the HIV (Human Immunodeficiency Virus) infection or been diagnosed as having ARC (AIDS Related Complex) or AIDS (Acquired Immune Deficiency Syndrome) caused by the HIV infection? Yes No
11. In the last 5 years, have you: (Circle those that apply.)
 - a. Received or been advised to receive a medical or surgical procedure? Yes No (If yes, explain.) _____
 - b. Had an application for life or health insurance rated, postponed, modified or declined (declined, not applicable in MO)? Yes No
12. In the last 12 months, have you used or been advised to take prescription drugs? Yes No (If yes, list medications and reason for their use.) _____
13. In the last 12 months, have you received or applied for Social Security Disability, Supplemental Security Income, Worker's Compensation, any other disability benefits, or are you disabled? Yes No (Describe disability.) _____
14. Will the coverage applied for replace or change any existing life insurance or annuity? Yes No

I declare the above answers are complete and true to the best of my knowledge and belief. I agree the answers will be part of the policy which will not be in force until the first premium is paid, the application is approved, and the policy is issued and delivered to me when I am in the same health condition stated above. **In MO, benefits paid for death by suicide during the first (one) year this policy is in effect are limited to return of premiums paid. However, in Kansas, until you receive your policy, insurance in force will be limited to \$1,000 and will be in force upon receipt of an application and a premium by the company. AUTHORIZATION:** I authorize any physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager or other medical related facility, insurance company, family member, the Medical Information Bureau, or other organization or person, that has record of me to give Starmount Life Insurance Company, my legal representative for medical records receipt, or its reinsurers, any information for the purpose of underwriting. This includes knowledge of drug

abuse, alcoholism or mental illness, and HIV (Human Immunodeficiency Virus) and/or AIDS (Acquired Immune Deficiency Syndrome) status; and, although this information may be protected by government regulation, I allow Starmount to collect it to determine insurability. I (or my authorized representative) am entitled to a copy of this authorization form and the information obtained. This authorization, or a copy of it is valid for 30 months (in KS and OK, 24 months) from the date of signature, but can be revoked at any time upon my written request. The treatment, payment, enrollment or eligibility for health benefits is not conditioned on my signing an authorization. I am aware the records may be subject to re-disclosure by the recipient and that re-disclosed information may no longer be protected by federal privacy regulations. I acknowledge receipt of the MIB Disclosure Notice. I authorize Starmount Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. (See below for fraud statements specific to your state.)

Insured's Signature: _____ **Date** _____

[**AGENT:** Does the proposed insured have an existing policy or contract, please sign below and list the policy or contract information as requested if you answer Yes. Yes No **Agent's (Producer) Signature:** _____ **Lic. No.:** _____

Please list the name of the insurer, policy or contract number or application number, if you answered Yes above: _____

Agent: Leave with the applicant the original or a copy of written or printed communications used for presentation to the applicant and submit a copy of the replacement notice with the application to the replacing insurer.]

(For Company Use) STAR I.D.: _____]

EXCLUSIONS: Exclusions may apply. Please see your policy for limitations and exclusions specific to your state.

FRAUD STATEMENTS:

For residents of Arkansas and Louisiana: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Kansas: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of a crime as determined by a court of law.

For residents of Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.



Policy Change Form

{DATE}

INSURED: {First_Name?} {Last_Name?}
{Address_Line_1?}, {Address_Line_2?}
{City?}, {State_Province?} {Zip?}

DOB: { }
Policy#: {A - PolicyNumber?}
Current Policy Amount: \${}

[OWNER: {First_Name?} {Last_Name?}]

[REINSTATEMENT:

Reinstate my policy in the amount of \$_____. (If no amount listed, current policy amount will be reinstated.)]

[INCREASE/DECREASE:

Change the face amount of my policy to \$_____.]

[CONVERSION:

Convert my policy to: [StarLife Gold (Form No. 21-001): Term Insurance to age 95]
[SelectLife (Form No. 51-001): Whole Life Insurance to age 120]

- [In the amount of \$ _____ {face amount} for \$ _____ {premium} or]
- [In the amount of \$ _____ {face amount} for \$ _____ {premium} or]
- [In the amount of \$ _____ {face amount} for \$ _____ {premium} or]]

ANSWER THE FOLLOWING QUESTIONS: (Must be completed by the Insured.)

- 1) Have you smoked, chewed or used tobacco in any form in the last 24 months? Yes No
If yes, do you smoke more than 2 packs per day? Yes No

- 2) In the last 5 years, have you been diagnosed with, or treated for any of the following conditions: (Circle each condition and explain yes answers.)
 - a) Cancer; tumor; polyps; stroke; hepatitis; any disease or disorder of the kidneys, heart, blood, liver or circulatory system; any chronic respiratory or lung disorder; or used oxygen to assist in breathing? _____ Yes No

 - b) Mental or nervous disorder; Alzheimer's; dementia; alcoholism; drug addiction; taken illegal drugs; abused prescription medication; been ticketed for DWI or DUI or had a felony conviction? _____ Yes No

 - c) Diabetes or high blood pressure? _____ Yes No
If yes, are you scheduling regular check-ups and taking medication as prescribed? Yes No

- 3) Have you ever (in MO, not to exceed 10 years) been positively diagnosed or treated for the HIV (Human Immunodeficiency Virus) infection or been diagnosed as having ARC (AIDS Related Complex) or AIDS (Acquired Immune Deficiency Syndrome) caused by the HIV infection? Yes No

- 4) In the last 5 years, have you: (Circle those that apply.)
 - a) Received or been advised to receive a medical or surgical procedure? (If yes, explain.) _____ Yes No

Insured's Initials _____

- b) Had an application for life or health insurance rated, postponed, modified or declined (declined, not applicable in MO)? Yes No
- 5) In the last 12 months, have you used or been advised to take prescription drugs? (If yes, list medications and reason for their use.) _____ Yes No
- 6) In the last 12 months, have you received or applied for Social Security Disability, Supplemental Security Income, Worker's Compensation, any other disability benefits, or are you disabled? (Describe disability.) _____ Yes No
- 7) What is your height (ft. in.)? _____ and weight (lbs.)? _____
- 8) What is the name of your physician or clinic? _____
 City _____ State _____ Zip _____

I declare the above answers are complete and true to the best of my knowledge and belief. I agree the answers will be part of the policy which will not be in force until the premium is paid, the application is approved, and the policy is [reinstated and the reinstatement approval letter] [increased and] [decreased and] [increased, converted and] [decreased, converted and] [converted and] delivered to me when I am in the same health condition stated above. **In MO, benefits paid for death by suicide during the first (one) year this policy is in effect are limited to return of premiums paid. However, in Kansas, until you receive your policy, insurance in force will be limited to \$1,000 and will be in force upon receipt of an application and a premium by the company.**

AUTHORIZATION: I authorize any physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager or other medical related facility, insurance company, family member, the Medical Information Bureau, or other organization or person, that has record of me to give Starmount Life Insurance Company, my legal representative for medical records receipt, or its reinsurers, any information for the purpose of underwriting. This includes knowledge of drug abuse, alcoholism or mental illness, and HIV (Human Immunodeficiency Virus) and/or AIDS (Acquired Immune Deficiency Syndrome) status; and, although this information may be protected by government regulation, I allow Starmount to collect it to determine insurability. I (or my authorized representative) am entitled to a copy of this authorization form and the information obtained. This authorization, or a copy of it is valid for 30 months (in KS & OK, 24 months) from the date of signature, but can be revoked at any time upon my written request. The treatment, payment, enrollment or eligibility for health benefits is not conditioned on my signing an authorization. I am aware the records may be subject to re-disclosure by the recipient and that re-disclosed information may no longer be protected by federal privacy regulations. I acknowledge receipt of the MIB Disclosure Notice. I authorize Starmount Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. (See below for fraud statements specific to your state.)

Fraud Statements:

For residents of Arkansas and Louisiana: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Kansas: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of a crime as determined by a court of law.

For residents of Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Home Phone: (____) _____ - _____ **Cell/Work Phone:** (____) _____ - _____ [SS # _____ - _____ - _____]

Insured's Signature: _____ **Date:** ____ / ____ / ____

[Owner's Signature: _____ **Date:** ____ / ____ / ____]

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Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification Comments: A Flesh certification for each submitted form has been attached. Attachments: UNVRSL1 RGN 4 FLESCHE.pdf PlcyChg1 RGN 4 FLESCHE.pdf</p>		
<p>Bypassed - Item: Application Bypass Reason: N/A - new application submission Comments:</p>		
<p>Satisfied - Item: UNVRSL1 Statement of Variability Comments: Attachment: UNVRSL1 StatementVariability.pdf</p>		
<p>Satisfied - Item: PlcyChg1 Statement of Variability Comments: Attachment: PlcyChg1 StatementVariability.pdf</p>		

STARMOUNT LIFE INSURANCE COMPANY

FLESCH READABILITY ANALYSIS

<u>FORM</u>	<u>WORDS</u>	<u>PARAGRAPHS</u>	<u>SENTENCES</u>	<u>SCORE</u>
PlcyChg1	1017	70	48	44.2

This is to certify that this form meets the minimum score on the Flesch reading ease test in the NAIC Life and Health Insurance Policy Language Simplification Model Act. The Flesch score has been measured by the method described in the act and reflects all text excluding only language or terminology in the following categories entitled to be excepted under the act: the name and address of the insurer; the name, number or title of the policy; the table of contents or index; captions and subcaptions; specifications pages, schedules or table; language required by law or regulation; medical terminology; and words which are defined in the policy.

Jeffrey G. Wild

Printed on Recycled Paper
Manufactured in the USA
www.starlife.com

Jeffrey G. Wild
Chief Financial Officer
Starmount Life Insurance Company

DATE: 3/21/2012

**UNIVERSAL APPLICATION FOR LIFE PRODUCTS
DEFINITION OF VARIABLE TEXT**

Below please find the variable texts in this life product. There is no other variable information submitted with this filing.

The following information listed in brackets contains variable information:

APPLICATION FORM –UNVRSL1

Heading and Form Numbers:

Individual life products –Term Life (21-001), Level Premium Whole Life (51-001) and Modified Whole Life (32-001) are bracketed for use for offering a specific life product. Text will be removed when other life products are not being offered per marketing campaign.

Accidental Death Rider Form No. 97-005 and Accelerated Benefit Rider Form #98-010 ACC are bracketed for removal when various marketing campaigns will not offer these riders with this product. Text will either be included or excluded per marketing campaign.

The website is bracketed because it will change depending on the product being offered at the time. We have various URLs for each of our products.

Insured's Demographic Information:

Social Security Number is bracketed for various marketing campaigns in which this option may not be offered. Social Security Number will not appear on the application when the application is used on the internet.

Policy Face Amounts:

Amounts of insurance are bracketed for various marketing campaigns that will only offer certain amounts. Amounts not to be offered during campaign will be removed. The amounts may vary \$3,000 up to \$250,000 depending on which product will be offered.

Payment Options:

Payment methods are bracketed for various marketing campaigns in which certain payment options may not be offered.

Questions:

Information referring to an Agent is bracketed for removal when the application is used in a direct mail marketing campaign and not sold by individual agents.

Spouse Application:

Spouse Information section is bracketed for removal when marketing campaign is only for current insured policyholder and not their spouse. All spousal information on application is bracketed for removal for this purpose. Text will either be included or excluded in its entirety per campaign.

**POLICY CHANGE FORM APPLICATION FOR LIFE PRODUCTS
DEFINITION OF VARIABLE TEXT**

Below please find the variable texts in this Policy Change Form. There is no other variable information submitted with this filing.

The following information listed in brackets contains variable information:

APPLICATION FORM –PlcyChg1

Form Options:

Reinstatement is bracketed for use when the form will be sent out to previous policyholders who are requesting that their policy be reinstated. Text will be removed when a reinstatement is not being offered per marketing campaign.

Increase/Decrease is bracketed for use when the form will be sent out to a policyholder who is requesting an increase or decrease in the face amount of their current policy. Text will be removed when an increase or decrease is not being offered per marketing campaign.

Conversion to individual life products –StarLife Gold (21-001) and Selectlife (51-001) is bracketed for use when the form is sent as an offer for the policyholder to convert to a specific life product. Text will be removed when a conversion is not being offered per marketing campaign. The language “In the amount of _____ for _____” is bracketed for use only when a conversion is being offered through a direct mail solicitation. The direct mail solicitations will provide multiple offers and the application will be personalized with different face amounts to convert to and the premium for each.

Declaration:

Within the declaration the words “reinstated and the reinstatement approval letter”, “increased and”, “decreased and”, “converted and”, “increased & converted”, and “decreased & converted” are bracketed for use depending on the use of the form.

Owner’s name and signature block:

The owner’s name and signature block are bracketed for use when the owner of a policy is different than the insured. If the owner and insured are different then both will be required to sign the policy change request.

Insured’s Demographic Information:

Social Security Number is bracketed for various marketing campaigns in which this option may not be offered.