

On the Life of \_\_\_\_\_ Under Policy # \_\_\_\_\_

**SPECIAL NOTE: To apply for an increase in face/specified amount, increasing/adding Children's Term Rider, Other Insured Rider or Level Term Rider, addition of any rider or benefits or requesting rate reduction or waiver removal, an underwriting application is needed along with this Policy Service Form.**

**LIFE INSURANCE ONLY (1-7)**

- 1.  Change Base Policy
- Change Rider/Type of Rider \_\_\_\_\_
  - Reduce Face Amount to \$ \_\_\_\_\_ (Universal, Term or Whole Life)
  - If Universal Change to Option  A  B (If Option B, full application is needed.)
  - Change of Smoker Classification. When did insured stop smoking cigarettes? \_\_\_\_\_
- Reduce Special Premium Classification. It is agreed that the nonforfeiture benefits in the policy after any change will be those guaranteed in writing at the new classification on the original issue date.
- Addition(s) and Deletion(s)
 

Add	Del.
<input type="checkbox"/>	<input type="checkbox"/> Waiver of Premium
<input type="checkbox"/>	<input type="checkbox"/> Waiver of Monthly Deduction
<input type="checkbox"/>	<input type="checkbox"/> Accidental Death Benefit \$ _____
<input type="checkbox"/>	<input type="checkbox"/> Guaranteed Purchase Option \$ _____
<input type="checkbox"/>	<input type="checkbox"/> Children's Term Rider (deletion only)
<input type="checkbox"/>	<input type="checkbox"/> Other Insured Rider (deletion only)
<input type="checkbox"/>	<input type="checkbox"/> Level Term Rider (deletion only)
<input type="checkbox"/>	<input type="checkbox"/> Other _____
- Change Premium to: Amount \$ \_\_\_\_\_

- 2.  Activate Automatic Premium Loan Provision
- 3.  Revocation of Request for Automatic Premium Loan
- 4.  LOAN in accordance with provisions of my policy for \$ \_\_\_\_\_ or  maximum amount available.  
**PLEASE BE SURE TO REVIEW YOUR LOAN PROVISION IN YOUR POLICY.**
- 5.  PARTIAL WITHDRAWAL for \$ \_\_\_\_\_ in accordance with provisions of my policy.  
**QUESTION #7 REQUIRED—PLEASE COMPLETE.**
- 6.  SURRENDER OF POLICY FOR CASH VALUE (Pay all cash values to me; and as consideration for such payment, I surrender my policy and release THE CINCINNATI LIFE INSURANCE COMPANY from any and all claims or demands which arise under the policy. **QUESTION #7 REQUIRED—PLEASE COMPLETE.**  
My policy is attached:  Yes  No  
If "No," please state reason: \_\_\_\_\_

**7. Internal Revenue Information**

- 1. I elect to have income tax withheld.
- 2. I elect NOT to have income tax withheld.

**Taxpayer Identification Number**

Enter your SSN/TIN.  
Social Security/Tax ID Number 

--	--	--	--	--	--	--	--	--	--

**Certification**—Under penalties of perjury, I certify that:

- 1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
- 2. I am not subject to backup withholding because: (1) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

Owner's Signature \_\_\_\_\_

Date \_\_\_\_\_

**HEALTH INSURANCE ONLY (8-11)**

- 8.  Change Policy to: Disability Policy.
  - Monthly Benefit of \$ \_\_\_\_\_ (Reduction Only)
  - Elimination Period to \_\_\_\_\_ Days
  - Benefit Period \_\_\_\_\_
  - Other \_\_\_\_\_
- Medical Coverage.
  - Deductible to \$ \_\_\_\_\_
  - Plan to: 80/20 or 70/30 (Please Circle)
- 9.  Exercise Future Increase Option (IDIP) [Proof of Income (W2 or 1040) and Initial Premium Required].
- 10.  Deletions—Cancel the following Rider(s)/Supplementary Benefit(s) or Individual(s).  
\_\_\_\_\_
- 11.  Remove Exclusion Waiver.  
 Remove/Reduce Special Premium Classification.

**GENERAL USE (12-14)**

- 12.  REQUEST FOR CERTIFICATE OF INSURANCE/LOST POLICY NOTIFICATION. I (We) state that the original policy has been lost, destroyed, or stolen and that it cannot be found, although diligent search has been made for it. I (We) agree to indemnify the Company from any and all claims, suits, damages, costs, or expenses to which it may be subjected or in any way made liable in consequence of the issuance of the certificate of insurance.
- 13.  Change of Premium Payment Method to:
 

<input type="checkbox"/> Annual	<input type="checkbox"/> Semi-Annual
<input type="checkbox"/> Quarterly	<input type="checkbox"/> Bank-O-Matic
- 14.  Special Request:

**EXERCISE GUARANTEED INSURANCE OPTION** (Universal Life Only) Under Policy # \_\_\_\_\_

Amount of Increase \$ \_\_\_\_\_ Effective Date \_\_\_\_\_ New Premium \$ \_\_\_\_\_  
 (Anniversary Date of Option)

Applying for Nonsmoker Rates  
 Amount Collected \$ \_\_\_\_\_ When did insured stop smoking cigarettes? \_\_\_\_\_

**EXERCISE GUARANTEED PURCHASE OPTION** (Traditional Life Only) Under Policy # \_\_\_\_\_

Plan \_\_\_\_\_ Amount of Insurance \$ \_\_\_\_\_ Effective Date \_\_\_\_\_  
 (Anniversary Date of Option)

Applying for Nonsmoker Rates  
 When did insured stop smoking cigarettes? \_\_\_\_\_

New Premium \$ \_\_\_\_\_ Amount Collected \$ \_\_\_\_\_

**PREMIUM PAYMENT METHOD** Bank-O-Matic Quarterly Semi-Annual Annual (please circle)

Should the new policy include the same supplemental benefits as above-stated policy as provided by the Guaranteed Purchase Option Rider Provisions?  Yes  No

**■ BENEFICIARY DESIGNATION AND OWNERSHIP DESIGNATION**, please complete Pages 3 and 4.

**REQUEST FOR CONVERSION**

**A. CONVERSION OF POLICY #:** \_\_\_\_\_

\_\_\_\_\_ Term Policy  
 \_\_\_\_\_ Term Rider (OIR Rider\*, Level Term Rider, Children's Term Rider\*)

\* \_\_\_\_\_  
 Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**B. CONVERT TO:** Option  A  B  
 \_\_\_\_\_  
 (Type of Plan)

\_\_\_\_\_  Additional Amount Being Requested.  
 (Amount of Insurance)

Yes  No Is this amount the full amount of current policy?  
 If "No," should balance be:  Continued  Cancelled  
 Yes  No Original policy attached. If "No," please indicate reason: \_\_\_\_\_

**C. ADDITIONAL BENEFITS**  
 (Indicate if benefits are to be deleted, continued or added. If added, additional Underwriting Requirements are needed.)

Delete	Continued	Add	
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Waiver of Premium
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Waiver of Monthly Deduction (UL Only)
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Accidental Death Benefit \$ _____
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Guaranteed Purchase Option \$ _____
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Children's Term Rider (DELETE ONLY)

Applying for Nonsmoker Rates  
 When did insured stop smoking cigarettes? \_\_\_\_\_

**D. PREMIUM PAYMENT METHOD** (please circle)  
 Bank-O-Matic Quarterly Semi-Annual Annual Payroll

(If payroll, new Payroll Authorization Form is needed.)  
 New Premium \$ \_\_\_\_\_ Amount Collected \$ \_\_\_\_\_  
 Yes  No Automatic Premium Loan?  
 Yes  No Is there an active assignment of collateral or irrevocable beneficiary? If "Yes," signatures are required on Page 4.)

**■ BENEFICIARY DESIGNATION AND OWNERSHIP DESIGNATION**, please complete Pages 3 and 4.

On the Life of \_\_\_\_\_ Under Policy # \_\_\_\_\_

This is to be completed and signed by the current owner (and new owner, if applicable); and if there currently is an irrevocable beneficiary, the form must be signed by the irrevocable beneficiary in order to process a request for beneficiary or ownership change. If the current owner is deceased, it will be necessary for the executor or administrator of the Estate to complete and sign the form and return it along with a copy of the probate papers. The form is to be witnessed by someone other than the new beneficiary or new owner.

**BENEFICIARY CHANGE/DESIGNATION**     If a trust is designated, please be sure the date of the trust is stated.

Please review the terms of the beneficiary designation before completing. If one or more beneficiaries are being named, please be sure it is indicated clearly as Primary and Contingent. If more than one primary or contingent beneficiary is being named, unless otherwise stated, the designation will be "Share and Share Alike." Any other split should be shown in percentages.

Primary Beneficiary:

	Social Security #/ Federal ID #		
<u>Name</u>		<u>Address</u>	<u>Relationship/Date of Birth</u>

Contingent Beneficiary:

	Social Security #/ Federal ID #		
<u>Name</u>		<u>Address</u>	<u>Relationship/Date of Birth</u>

(If additional space is needed, a separate sheet can be attached. Please make sure both forms are signed, dated and witnessed.)

All previous beneficiary designation and settlement options are hereby revoked and the above designation is made. It is understood that the Company shall not be bound by any trust deed or partnership agreement and shall not be liable for the application of the proceeds of the policy by any trustee beneficiary or any other person.

**NAME CHANGE/CORRECTION**

The name of the \_\_\_\_\_ needs to be changed to: \_\_\_\_\_

On the Life of \_\_\_\_\_ Under Policy # \_\_\_\_\_

OWNERSHIP DESIGNATION  If a trust is designated, please be sure the date of the trust is stated.

I transfer or designate all my rights, title and interest as owner of the above policy to:

Primary Owner:

<u>Name</u>	<u>Social Security #/ Federal ID #</u>	<u>Address</u>	<u>Relationship</u>	<u>Date of Birth</u>
-------------	--	----------------	---------------------	----------------------

Contingent Owner, to become owner upon death of above-stated owner:

<u>Name</u>	<u>Social Security #/ Federal ID #</u>	<u>Address</u>	<u>Relationship</u>	<u>Date of Birth</u>
-------------	--	----------------	---------------------	----------------------

Transfer is subject to any loan or advance made by the Company on the security of the policy and to the rights of the Company in connection therewith and to any assignment of the policy in force and on file with The Cincinnati Life Insurance Company. I declare that no insolvency or bankruptcy proceedings are pending against me and that I have not executed any assignment not on file with The Cincinnati Life Insurance Company.

**CURRENT MAILING ADDRESS**  Check here if new address

Insured's \_\_\_\_\_

Owner's \_\_\_\_\_

**IRREVOCABLE BENEFICIARY/ASSIGNEE**

If there is an assignment or irrevocable beneficiary on the current policy, conversion can only be processed with the approval of the Assignee or irrevocable beneficiary or upon receiving a Release from the Assignee, if not applicable to the new policy.

**X** \_\_\_\_\_  
Signature of Irrevocable Beneficiary, Loan Officer, Title \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

I (WE) HAVE READ THE STATEMENTS AND ANSWERS IN THIS POLICY SERVICE FORM. TO THE BEST OF MY (OUR) KNOWLEDGE AND BELIEF, THEY ARE COMPLETE AND TRUE.

**SIGNATURE SECTION**

**Taxpayer Identification Number**

Date: **X** \_\_\_\_\_

Enter Owner's SSN/TIN.

Social Security/Tax ID Number 

--	--	--	--	--	--	--	--	--	--

**X** \_\_\_\_\_  
Signature of Owner (If firm or corporation, print company name and have company officer sign with title.)

**X** \_\_\_\_\_  
Witness Signature or Licensed Agent/Agent Code #

**X** \_\_\_\_\_  
Signature of new Owner, if not current owner of policy. (If firm or corporation, print company name and have company officer sign with title.)

**ACKNOWLEDGMENT BY COMPANY:** The Cincinnati Life Insurance Company hereby acknowledges the change or changes shown above upon the conditions herein set forth.

Date \_\_\_\_\_ Countersigned by: \_\_\_\_\_  
Cincinnati, Ohio \_\_\_\_\_ Secretary