

American General

Assurance Company

Name: _____ Date: _____

Address: _____ Credit Union Name: _____

City: _____ ST _____ Zip _____ Account Number: _____

CHANGE FORM

Accidental Death & Dismemberment Insurance

1 Please change amount of Supplemental Coverage to:

<table border="0" style="width: 100%;"> <tr> <td style="width: 10%;">Acct. Holder</td> <td style="width: 10%;">Family</td> <td style="width: 80%;"></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>\$10,000</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>\$20,000</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>\$25,000</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>\$30,000</td> </tr> </table>	Acct. Holder	Family		<input type="checkbox"/>	<input type="checkbox"/>	\$10,000	<input type="checkbox"/>	<input type="checkbox"/>	\$20,000	<input type="checkbox"/>	<input type="checkbox"/>	\$25,000	<input type="checkbox"/>	<input type="checkbox"/>	\$30,000	<table border="0" style="width: 100%;"> <tr> <td style="width: 10%;">Acct. Holder</td> <td style="width: 10%;">Family</td> <td style="width: 80%;"></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>\$40,000</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>\$50,000</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>\$60,000</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>\$75,000</td> </tr> </table>	Acct. Holder	Family		<input type="checkbox"/>	<input type="checkbox"/>	\$40,000	<input type="checkbox"/>	<input type="checkbox"/>	\$50,000	<input type="checkbox"/>	<input type="checkbox"/>	\$60,000	<input type="checkbox"/>	<input type="checkbox"/>	\$75,000	<table border="0" style="width: 100%;"> <tr> <td style="width: 10%;">Acct. Holder</td> <td style="width: 10%;">Family</td> <td style="width: 80%;"></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>\$100,000</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>\$125,000</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>\$150,000</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>\$175,000</td> </tr> </table>	Acct. Holder	Family		<input type="checkbox"/>	<input type="checkbox"/>	\$100,000	<input type="checkbox"/>	<input type="checkbox"/>	\$125,000	<input type="checkbox"/>	<input type="checkbox"/>	\$150,000	<input type="checkbox"/>	<input type="checkbox"/>	\$175,000	<table border="0" style="width: 100%;"> <tr> <td style="width: 10%;">Acct. Holder</td> <td style="width: 10%;">Family</td> <td style="width: 80%;"></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>\$200,000</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>\$225,000</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>\$250,000</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other: _____</td> </tr> </table>	Acct. Holder	Family		<input type="checkbox"/>	<input type="checkbox"/>	\$200,000	<input type="checkbox"/>	<input type="checkbox"/>	\$225,000	<input type="checkbox"/>	<input type="checkbox"/>	\$250,000	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
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2 I want to: (Check Appropriate Box)

- | | |
|--|---|
| <input type="checkbox"/> Cancel All Coverage

<input type="checkbox"/> Cancel Family Coverage
<i>(Leaves Individual Coverage)</i> | <input type="checkbox"/> Cancel Supplemental Coverage
<i>(No cost, Basic Coverage remains in effect)</i>

<input type="checkbox"/> Add Family Coverage |
|--|---|

Reason for cancellation:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Primary Member Deceased | <input type="checkbox"/> Spouse Deceased | <input type="checkbox"/> Rates Too High | <input type="checkbox"/> Duplicate Coverage |
| <input type="checkbox"/> Closed Account | <input type="checkbox"/> No Longer Need Insurance | <input type="checkbox"/> Billing Information Was Not Clear | |
| <input type="checkbox"/> Other: _____ | | | |

3 Change my name, account number, or address:

- | | | |
|---|-------------|--|
| <input type="checkbox"/> Name | From: _____ | |
| | To: _____ | |
| <input type="checkbox"/> Address | From: _____ | |
| | To: _____ | |
| <input type="checkbox"/> Account Number | From: _____ | Checking <input type="checkbox"/> Savings <input type="checkbox"/> |
| | To: _____ | Checking <input type="checkbox"/> Savings <input type="checkbox"/> |

Member's Signature: _____ Dated: _____

Please retain a copy of this form for your records.

For Office Use Only

The change requested is complete and recorded on behalf of American General Assurance Company subject to the terms and conditions of the group policy, and a copy returned for your files.

By: _____ Date: _____