

The
United States Life
 Insurance Company in the city of New York

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:

Acct. Holder	Family		Acct. Holder	Family		Acct. Holder	Family		Acct. Holder	Family	
<input type="checkbox"/>	<input type="checkbox"/>	\$10,000	<input type="checkbox"/>	<input type="checkbox"/>	\$40,000	<input type="checkbox"/>	<input type="checkbox"/>	\$100,000	<input type="checkbox"/>	<input type="checkbox"/>	\$200,000
<input type="checkbox"/>	<input type="checkbox"/>	\$20,000	<input type="checkbox"/>	<input type="checkbox"/>	\$50,000	<input type="checkbox"/>	<input type="checkbox"/>	\$125,000	<input type="checkbox"/>	<input type="checkbox"/>	\$225,000
<input type="checkbox"/>	<input type="checkbox"/>	\$25,000	<input type="checkbox"/>	<input type="checkbox"/>	\$60,000	<input type="checkbox"/>	<input type="checkbox"/>	\$150,000	<input type="checkbox"/>	<input type="checkbox"/>	\$250,000
<input type="checkbox"/>	<input type="checkbox"/>	\$30,000	<input type="checkbox"/>	<input type="checkbox"/>	\$75,000	<input type="checkbox"/>	<input type="checkbox"/>	\$175,000	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

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 requested change is complete and recorded on behalf of United States Life Insurance Company in the City of New York and a copy returned for your files.

By: _____ Date: _____