



**Headquarters:** 6200 S. Gilmore Road, Fairfield, OH 45014-5141  
**Mailing address:** P.O. Box 145496, Cincinnati, OH 45250-5496  
 cinfin.com ■ 513-870-2000

**POLICY SERVICE FORM**

Insured Name \_\_\_\_\_  
 Policy Number \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Change of Mailing Address**  
 This change applies to:  Insured  Owner  Payer  Assignee  Beneficiary  Secondary Addressee  
 \_\_\_\_\_  
 Street Address or P.O.Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Beneficiary Change/Designation**  
 If a trust is designated, please state the date of the trust \_\_\_\_\_  
 Please review the terms of the beneficiary before completing. If multiple beneficiaries are being named, unless otherwise stated, the designation will be Share and Share Alike. If the beneficiary split is other than Share and Share Alike, it should be reflected in the percentages and equal 100%.

Primary Beneficiary (include name and address)	Relationship	SS#	% Benefit

Contingent Beneficiary (include name and address)	Relationship	SS#	% Benefit

(If additional space is needed, a separate sheet can be attached. Please date, sign and witness both forms.)

All previous beneficiary designations 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.

**Ownership Designation (Please attach a required W-9 if completing this section.)**  
 If a trust is designated, please state the date of the trust \_\_\_\_\_  
 I transfer or designate all my rights, title and interest as owner of the above policy to:

**Primary Owner:**

_____	_____	_____	_____
Name	Relationship	SS#	Date of Birth
_____	_____	_____	_____
Street Address or P.O. Box	City	State	Zip Code

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

_____	_____	_____	_____
Name	Relationship	SS#	Date of Birth
_____	_____	_____	_____
Street Address or P.O. Box	City	State	Zip Code

Is the Owner also the Payer:  Yes  No (If no please complete Payer information below)

**Payer:**

_____	_____	_____	_____
Name	Relationship	SS#	Date of Birth
_____	_____	_____	_____
Street Address or P.O. Box	City	State	Zip Code

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 not 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.

**Name Change/Correction (Please attach a required W-9 if completing this section.)**

This change applies to:  Insured  Owner  Payer  Assignee  Beneficiary  Secondary Addressee

From \_\_\_\_\_ To \_\_\_\_\_

Reason \_\_\_\_\_

**Addition of Child to Existing Children's Term Rider**

The employee will be the owner and the beneficiary unless otherwise stated.

Full Name of Proposed Insured Children	Date of Birth	Gender	Relationship to Employee
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Child born to you <input type="checkbox"/> Legally adopted
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Child born to you <input type="checkbox"/> Legally adopted

**Lost Policy Certificate or Duplicate Policy Request**

I certify to the best of my knowledge that the original policy has been lost, destroyed or stolen and cannot be found. I further declare that said policy has not been sold, assigned or transferred and that no person, party or corporation holds any legal or equitable claim, trust or charge on said policy. I agree to hold the company harmless from any claims that may arise from the original contract.

Replacement option (select one):  Policy certification  Duplicate policy (may not be available for all policies)

**Signature Section**

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

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 of Owner (If business, print company name and have office sign with title.)      Date

\_\_\_\_\_  
Witness Signature or Licensed Agent and Agent Code #      Date

\_\_\_\_\_  
Signature of New Owner, if not Current Owner of Policy      Date

\_\_\_\_\_  
Signature of Irrevocable Beneficiary, Loan Office, Title      Date