LOYAL AMERICAN LIFE INSURANCE COMPANY
P.O. Box 559004 · Austin, Texas 78755-9004 · (800) 633-6752

POLICY CHANGE FORM

Name ______________________ **Phone No.** ______________________

Address ____

Date of Birth ______________________ **Social Security No.** ______________________

To request a change in your insurance coverage, please complete the applicable section below. When requesting a reinstatement or increase in coverage, <u>the questionnaire on the reverse side must be completed in full.</u> Be sure to sign your name in both places indicated below.

☐ **Reinstate Policy Number** ______________________ (Complete the questionnaire on the reverse side of this form.)

☐ **Convert Policy Number** ______________________

Please convert my existing coverage to one of the following plans (Please specify plan desired):

- ☐ Medicare Supplement (Must have Medicare Parts A & B) (Complete questionnaire on the reverse side of form if coverage increase.)
- ☐ Comprehensive Long Term Care (Complete questionnaire on the reverse side of form.)
  Please specify options desired. ____
  ____
  ____
  ____
- ☐ Please specify which Riders wanted, if any ____

☐ **Change Benefit Coverage on Policy Number** ______________________
(Complete the questionnaire on the reverse side for coverage increase.)

- ☐ Change amount of Daily Benefit, from $_________ a day to _________ a day.
- ☐ Change in Elimination Period, from _________ days to _________ days.
- ☐ Change Benefit Period, from _________ years to _________ years.
- ☐ Remove Exclusion Endorsement
- ☐ Add Rider ____
- ☐ Remove Rider ____
- ☐ Other ____
  ____

I hereby request the changes marked above: X ____
Signature Date

AUTHORIZATION

I hereby represent that the foregoing answers are recorded as given by me and that the same are full, complete and true to the best of my knowledge and belief. I represent that all questions on this form were answered and properly recorded. I further agree that the insurance applied for shall be subject to the conditions and provisions of the policy and shall not be in force until the changes are approved by the Company. I represent that I am not covered by a State Medicaid Program. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, the U.S. Veteran's Administration and Selective Service System, insurance company, The Medical Information Bureau, or other organization, institution or person, that has any records or knowledge of me or my health to give to Loyal American Life Insurance Company and its reinsurers any such information. I agree that this form shall become a part of any policy issued. **<u>I understand that any false statement or misrepresentation therein which is material to the risk or hazard assumed may result in a loss of coverage under the policy subject to the Time Limit on Certain Defenses and legal proceedings..</u>** A photographic copy of this authorization shall be as valid as the original.

X ____
Signature Date

Complete the medical information section if you are: (1) requesting reinstatement of a lapsed policy; (2) requesting any increase in coverage, or (3) requesting conversion to a different policy. Please be sure to sign and date the Authorization on the reverse side of this form.

		YES	NO
1. MEDICAL INFORMATION: To the best of your knowledge, have you or any family member to be insured ever:			
A. Been medically treated for, medically advised of or had symptoms of any of the following: (circle condition and explain below)			
1. Cancer, tumor, growth, skin condition, blood condition, immune system disorder or anemia	____________	☐	☐
2. Paralysis, epilepsy, Alzheimer's disease, Parkinson's disease, brain disorder or any mental or nervous condition	____________	☐	☐
3. Abnormal blood pressure, heart attack, stroke, heart condition, pacemaker or circulatory condition	____________	☐	☐
4. Asthma, emphysema, pneumonia, bronchitis, or any lung or respiratory condition	____________	☐	☐
5. Ulcer of the stomach or intestines, liver disease, gallbladder disease or other digestive disorder, intestinal disorder, rectal bleeding or other rectal condition, hemorrhoids or Crohn's disease	____________	☐	☐
6. Any kidney condition, genitourinary condition, prostate condition, or venereal disease	____________	☐	☐
7. Female condition or breast condition	____________	☐	☐
8. Osteoarthritis, rheumatoid arthritis, rheumatism, back, spine, bone, joint or muscle or nerve condition	____________	☐	☐
9. Thyroid condition, diabetes, gout, any condition of the eyes, ears, nose or throat	____________	☐	☐
10. Addison's disease, amyotrophic lateral sclerosis, diphtheria, encephalitis, Legionnaire's disease, lupus erythematosus, meningitis, muscular dystrophy, multiple sclerosis, myasthenia gravis, Niemann-Pick disease, osteomyelitis, poliomyelitis, rabies, Reye's _ Syndrome, rheumatic fever, Rocky Mountain Spotted Fever, scarlet fever, sickle cell anemia, smallpox, Tay-Sachs disease, __ tetanus, toxic epidermal necrolysis, toxic shock syndrome, tuberculosis, tularemia, typhoid fever, or Whipple's disease	____________	☐	☐
11. Been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex, Human Immunodeficiency Virus (HIV) Infection, or are HIV positive?	____________	☐	☐
12. Been treated for or exhibited signs of drugs or alcohol abuse?	____________	☐	☐
B. Had any impairment or disease not listed above?	____________	☐	☐
C. Been advised to have an operation which has not been performed?	____________	☐	☐
D. Currently pregnant? If yes, what month?	____________	☐	☐
E. Had any complications of pregnancy?	____________	☐	☐
F. In the last 5 years:			
1. Missed more than 5 consecutive days from work/school due to sickness or injury?	____________	☐	☐
2. Been a patient in a hospital, clinic, nursing home or other medical facility?	____________	☐	☐
3. Had a checkup, consultation, diagnostic tests, illness, surgery, disease or medical treatment not mentioned above, or leave of absence or sabbatical?	____________	☐	☐
4. Been advised to have future or surgical treatment, leave of absence or sabbatical, or Home Health Care?	____________	☐	☐
G. Now confined in a hospital, nursing home, other health care facility or are a resident of a retirement center? (if yes, circle facility)	____________	☐	☐
H. Applied for or now receiving Social Security disability benefits?	____________	☐	☐

I. Current weight ______________ height ______________

J. Have you ever smoked? ☐ Yes ☐ No If so, how much?______________ If quit, when?______________

Name and Address of Physician(s): ____

Date of Last Visit: ______________________ Reason: ______________________

Results: ____

Current Medications: ____

EXPLANATION OF ABOVE QUESTIONS: ____

____

Note: Please be sure you sign and date the authorization on the reverse side of this form.