Policy Service Request *(Policy Required if indicated)*

ManhattanLife, PO Box 926169, Houston, TX 77092

Fax: 1-855-710-6864

Insured's Name ______________________________ Policy Number ______________________________ Owner's Name ______________________________X___ Owner's Social Security Number ____________________ Owner's Address

City ______________________________ State ______________________ ZIP+4 ____________

Owner's Telephone ____

☐**Section A — Payor Address Change**

Address ____

City ______________________________ State ______________________ ZIP+4 ____________

☐**Section B — Legal Name Change** *(Does not change designation)*

☐ Beneficiary ____

Relationship ______________________________ Date of Birth ________/________/________

☐ Insured ____

☐ Contingent Beneficiary ____

☐ Applicant ______________________________ Payor ______________________________

☐ Owner ____

☐**Section C — Premium Changes** *(Requires Home Office approval)*

Change Premium Payment: ☐ Annual ☐ Semi-annual | ☐ Direct Bill

☐ Quarterly ☐ Monthly | ☐ Bank Draft *(Bank Authorization & voided check required)*

Contact Home Office for Special Request and Minimum Requirements.

☐ **Section D — Convert Insurance To:**

Product/Plan ______________________________ Modal Premium ______________________________

Insurance Amount ______________________________ Effective ________/________/________

Tobacco User: ☐ Yes ☐ No Have you used tobacco products in the last 12 months? ☐ Yes ☐ No

A urine specimen is required if original was not a NTU Plan.

☐Continue Remaining Insurance, or ☐Cancel Remaining Insurance

	Continue	**Terminate**
☐ Children's Rider	☐	☐
☐ Waiver of Premium	☐	☐
☐ AD&D Rider	☐	☐

Dividend Option: *(Complete Form 6106 Section A for Paid-up Additions)*

☐Paid in Cash ☐Left to Accumulate

☐ **Section E — Policy Value Options** *(Premium must be current)*

I request that my policy be placed on: ☐Reduced Paid-Up Insurance ☐Extended Term Insurance

Discontinue Premium Payments Effective ________________/________________/________________

(If requesting premium reduction via dividend, complete Form 6096)

☐ **Section F — Plan Change, Reduction and/or Removal**

Coverage Change Effective ________________/________________/________________

☐Change product/plan of insurance: From ____________________ To ____________________

☐Reduce amount of insurance to: ____

☐Remove Dependent, Benefit or Rider ____

(Complete Form 6106 if changing plan from Tobacco User to Non-Tobacco User.)

☐ Change Date of Birth to ______/________/________ Name of Insured that Change Applies to ____________________

If the Policy requires that the above change(s) be endorsed in the Policy, it is requested that the Policy be modified to permit the change(s) without endorsement of the Policy.

Signature ______________________________ ________/________/________

Policyowner Date