Instructions for Requesting Duplicate Policy or Policy Summary

There is a \$25.00 duplicate policy fee required for a duplicate policy. We are not able to provide duplicate policies for all plans. You may wish to contact the administrative office at 1-833-508-0404 to determine if a duplicate policy is available.

Please make the check payable to State Mutual Insurance Company. A policy summary is available at no cost to you.

To request either of these please complete section 5 of the form. Please complete all of the requested information and sign at the bottom of the form. **Your signature must be witnessed by a disinterested party.**

If the form is received without payment a Policy Summary will be provided. If we receive a check and a Duplicate Policy is not available, we will provide a Policy Summary and refund the \$25.00 to you.

We cannot accept faxed forms.



STATE MUTUAL INSURANCE COMPANY
P.O. BOX 11864
WINSTON SALEM, NC 27116
1-833-508-0404 (TOLL FREE)

POLICY CHANGE REQUEST

POLICY NO.	INSURED	OWNER
The undersigned hereby requests and directs the Company to make the following changes or take the action requested below. (Check the section(s) you want changed and complete the required information.)		
Section 1. CHANGE OF NAME		
OF: OWNER INSURED BENEFICIARY TO:		
REASON: MARRIAGE D	DIVORCE* COURT DECREE* COURT DECREE MAY BE R	CORRECTION* ADOPTION* EQUIRED.
Section 2. CHANGE OF OWNERSHIP		
TO:	TAX ID #/SS #	
From this time forward, the Owner designated above may exercise every privilege and enjoy every benefit granted to the Owner under this policy. (Enter new owner's address below) NOTICES TO OWNER UNLESS CHECKED HERE		
Section 3. CHANGE OF BENEFICIARY		
FULL NAME	ADDRESS	% RELATIONSHIP
PRIMARY:		
CONTINGENT:		
If more than one beneficiary is listed as Primary or Contingent, proceeds shall be paid in equal shares. List full given name		
	the Beneficiary is a partnership, give the nar	nes of partners.
Section 4. ASSIGNMENT RELEASE		
For value received, the undersigned Assignee hereby releases all right, title and interest in this policy.		
Section 5. REQUEST FOR POLICY SUMMARY/DUPLICATE POLICY		
This policy has been lost or destroyed. If the policy is found later, I agree to surrender it to the Company without claim. A Policy Summary will be sent unless request is accompanied by a duplicate policy fee of \$25.00. (For some plans or insurance, duplicate policy forms may not be available.)		
SIGNATURES OF POLICY OWNER AND/OR ASSIGNEE REQUIRED		
I REQUEST that this change be recorded in the Home Office records. I revoke all former designations made by me. I make this election subject to all the conditions and provisions of the Policy, as well as any existing assignments. I waive any policy requirement for endorsement of the policy before the change approved by the Company becomes effective.		
OWNER SIGNATURE	TAX I	D#/SS#
ADDITIONAL SIGNATURE (if Required)	SHOW TITLE IF SIGNED ON BEHALF OF COR	POPATION
OWNED/C ADDDECC		
NUMBER NUMBER	STREET	CITY STATE ZIP
WITNESS SIGNATURE*		
*WITNESS MUST BE AN UNRELATED ADULT PERSON WITH N	O INTEREST IN THE POLICY PRINTER) NAME
IMPORTANT: DO NOT USE CORRECTION FLUID ON THIS FORM. IF YOU HAVE MADE AN ERROR, MARK THROUGH IT AND INITIAL YOUR CHANGE.		
HOME OFFICE USE ONLY This request has been filed with the Company at its Home Office.		
DATE.		
BYDATE		