State Mutual Insurance Company

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

REQUEST FOR POLICY CHANGE

INSTRUCTIONS

Use this form if you wish to:

1. Add Benefits. Complete Section 1 and 1-B if required.
2. Cancel Benefits. Complete Section 1

POLICY REQUIRED

3. Change Plan of Insurance. Complete Sections 1 and 1-B if required.
4. Convert from Term to Permanent Insurance. Complete Section 1. The undersigned hereby requests and directs the company to make the following changes.

APPLICATION FOR REINSTATEMENT BY REDATING

INSTRUCTIONS

1. Answer questions in Section 1-B Declaration of Insurability.
2. If reinstated policy is to remain as originally issued, check here
3. If changes are desired in reinstated Policy, complete those sections of Section 1 you want changed.

I hereby make application for reinstatement by redating of the above policy, which lapsed for non-payment of premium. All information contained in the original application is to be part of the reissued policy except as noted below.

POLICY NO.	INSURED	OWNER

SECTION 1: PLAN CHANGE

PLAN _____ AMOUNT _____ AGE _____

PREMIUM _____ MODE ANNUAL SEMI-ANNUAL QUARTERLY PAC OTHER _____

BENEFICIARY:	FIRST	MIDDLE	LAST NAME	RELATIONSHIP	AGE
PRIMARY					
CONTINGENT					

OWNERSHIP (if other than insured)

NAME _____ SS NO. _____

ADDRESS _____ ZIP _____

RIDERS	ADD*	DELETE	DIVIDEND OPTIONS	ADD
Premium Waiver			Paid Up Additions*	
Double Indemnity			Cash	
Payor			Accumulate	
			Reduce Premiums	

*Requires completion of Declaration of Insurability questionnaire – Section 1-B.

SECTION 1-A: COMPLETE FOR FAMILY INSURANCE ONLY

ADD FAMILY INSURANCE RIDER – Answer all questions, Declaration of Insurability questionnaire – Section 1-B

Name of Family Member to be Insured	Relationship to Insured	Date of Birth	Place of Birth	Age	Height	Weight	Insurance in Force

AUTOMATIC PREMIUM LOAN PROVISION WILL BE INCLUDED, IF AVAILABLE, UNLESS CHECKED HERE

SPECIAL INSTRUCTIONS	HOME OFFICE AMENDMENTS

SEE OTHER SIDE FOR SIGNATURE REQUIREMENTS AND SECTIONS 1-B and 1-C

SECTION 1-B: DECLARATION OF INSURABILITY IN LIEU OF MEDICAL EXAMINATION (APPLICABLE TO INSURED)

QUESTIONS	ANSWERS					
So far as you know and believe, have you or any member to be insured (check appropriate answer)	Insured		Payor		Dependent	
1. Any physical or mental impairment?	Yes	No	Yes	No	Yes	No
2. Had application for or reinstatement of Life or A & H insurance declined or rated?						
3. Been a patient of any hospital or sanitarium during the past two years?						
4. Gained or lost weight in the last year?						
5. For Females: Have you had any female trouble, tumor or disease of the breast, miscarriage, abnormal labor?						
6. Plan any foreign travel or residence?						
7. Have you, or any family member to be insured had:						
a. Heart or Circulatory trouble?						
b. Kidney or Urinary disorders?						
c. Lung or respiratory trouble?						
d. Diabetes or sugar in urine?						
e. Any digestive or stomach disorders?						
8. Consulted or had treatment from any Physician or Practitioner for any cause not mentioned above within the past five years? List family doctors.						
9. Does a person to be covered now have, or has he ever had cancer in any form?						

SECTION 1-C COMPLETE FOR "YES" ANSWER

NAME	DISEASE OR DISORDER	DATE	DETAILS	NAME AND ADDRESS OF PHYSICIAN

What is the present occupation of:

(a) Insured:	(b) Payor (If Payor Benefits Included)	(c) Dependents (if Covered)

THE COMPANY IS HEREBY AUTHORIZED TO AMEND THIS REQUEST TO CORRECT OBVIOUS ERRORS OR OMISSIONS:

IT IS AGREED that reinstatement is based on statements in this application, and those in the original application, and is contingent upon approval at the Company's Home Office, and payment of the first premium required for Reinstatement by Redating. Falsity of any answer made with intent to deceive or materially affecting acceptance of the risk, shall, for two years from date of reinstatement, bar right to recover under the policy. If not approved, any amount paid will be refunded, and any receipt previously issued is void.

I AGREE (1) that this application, and Declaration of Insurability, if required, shall be considered an amendment and supplement to the original application, and shall form a part of the policy; (2) that if the Declaration of Insurability is required, the changes requested shall not be effective until approved in the Home Office, and any required premium has been paid; (3) that falsity of any answers made with intent to deceive or materially affect acceptance of the risk, shall, for two years from Date of Change, bar right to recover under the policy.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution, or person, that has any records or knowledge of me or may health, or the health of any person on whose life insurance is herein applied for, to give to the State Mutual Insurance Company, and its reinsurers, any such information. A photographic copy of this authorization shall be as valid as the original.

I ACKNOWLEDGE receipt of notice of Fair Credit Reporting Act of 1970 (Notice to Applicant-Part One) and Pre-Notice relating to Medical Information Bureau, (Notice to Applicant-Part Two).

I UNDERSTAND the Company has waived any policy requirement for endorsement of the policy before any requested change approved by the Company becomes effective.

ANSWERS to all Health Questions are correct to the best of my knowledge and belief.

IF SECTION 1-B COMPLETED SIGNATURES OF: (1) INSURED ASSIGNEE OR (2) INSURED/APPLICANT.

INSURED – APPLICANT

WITNESS - AN UNRELATED ADULT PERSON WITH NO INTEREST IN THE POLICY DATE

ADDRESS ZIP

ASSIGNEE – OWNER

WITNESS - AN UNRELATED ADULT PERSON WITH NO INTEREST IN THE POLICY DATE

THE FOLLOWING FORM OF EXERCISE IS TO BE USED IF ANY OWNER OR ASSIGNEE IS A CORPORATION

NAME OF CORPORATION

BY

PRESIDENT OR VICE PRESIDENT

SECRETARY OR TREASURER DATE

Corporate Seal * *If Corporate Seal is not available, send a copy of Resolution of the Board of Directors authorizing the above action.

AUTHORIZATION FOR RELEASE OF INFORMATION

This is a HIPAA Compliant Authorization

Applicant/Policyholder Name: _____

Date of Birth: _____

Policy Number: _____

Person/Organizations providing the information:

Any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medicare, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration, or other medical or medical related facility that has my records, knowledge of me or my health, information as to diagnosis, treatment or prognosis with respect to the physical or mental condition concerning me.

Persons/organizations receiving the information:

Description of information to be released:

The entire medical record and any other protected health information concerning me within the past years, without restrictions.

Description of Reason for Disclosure:

The protected information is to be disclosed under this authorization so that the company may underwrite my application for insurance, determine eligibility for insurance, risk rating or certificate (policy) issuance determinations; obtain reinsurance and determine or fulfill responsibility for coverage and provision of benefits; administer coverage; and conduct other legally permissible activities that relate to any coverage I have, or have applied for.

I hereby authorize the use or disclosure of my individually identifiable health information as described above.

- I understand that if I refuse to sign this authorization to release the complete medical records and protected health information, or have any restriction on the release of the protected health information of me, the company will not be able to process the application, or if coverage has been issued, may not be able to make any benefit payments.
- I understand that any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information.
- I understand that I may revoke this authorization at any time by notifying the Requesting Person or Organization in writing at the address above. I understand that such revocation will not have any effect on actions the plan took prior to their receiving the revocation notice.
- I understand that I (or my authorized representative) am entitled to a copy of this form upon request.
- I understand that this authorization will expire 24 months from the date of this authorization.

☐

_____ _____

Signature of Applicant/Policyholder or Authorized Representative* **Date**

***If signed by the Applicant/Policyholder's Authorized Representative, documentation of representative's authority to act on behalf of Applicant/Policyholder must be attached to this form. Examples: Power of Attorney, Guardianship, Court Order, or Notarized Letter of Authorization from the Applicant/Policyholder.**

State Mutual Insurance Company

NOTICE TO APPLICANT – PART ONE

As part of our underwriting procedure, a routine investigative consumer report may be made during the next few days. This report typically concerns information on an applicant's character, general reputation, personal characteristics and mode of living except as may be related directly or indirectly to your sexual orientation. This information will be obtained through personal interviews with your friends, neighbors and associates. We will be pleased to provide you with further information on the nature and scope of such report. Check here if an interview is desired

Upon your written request, you are entitled to receive a copy of such report, if one is made.

NOTICE TO APPLICANT – PART TWO

Information regarding your insurability will be treated as confidential. However, State Mutual Insurance Company may make a brief report to the MIB Group (formerly Medical Information Bureau) a non-profit membership organization of life insurance companies operating as an information exchange for its members. If you apply to another MIB Group member Company for life or health insurance or a claim is submitted to such a company, upon request the MIB Group will supply the company with information it has in its file.

Upon receipt of a request from you, MIB Group will arrange disclosure of any information it has in your file. If you question the accuracy of information in the file, you may contact the MIB Group and seek a correction in accordance with the procedures in the Fair Credit Reporting Act. The MIB Group's information address is P.O. Box 105, Essex Station, Boston, Massachusetts 02112, (866) 692-6901.

State Mutual Insurance Company, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.