



Allstate

Workplace Division

American Heritage Life Insurance Company
Allstate Workplace Division
1776 American Heritage Life Drive
Jacksonville, Florida 32224

Telephone 1-800-521-3535
Facsimile 866-428-2513
www.allstateatwork.com

Agent Use Only – subject to AHL rules, send all items to be returned to: Agent Owner

Agent Name and Number _____

Policy Number(s) _____ Policy Owner's Name _____

Insured's Name if different than Owner _____

Policy Owner Mailing Address _____
(Street) _____ (Apt) _____

(City) _____ (State) _____ (Zip) _____

Check if this is a new address

Home Phone Number _____ Alternate Phone Number _____ (Cell or Work)

Preferred contact number (Home or Alternate) and best time to call if possible _____ a.m. p.m.

Email _____ Agent Name and Number _____

1. Policy Changes, Reductions or Removals

- Change from Family to Individual Coverage Individual and Spouse Coverage
- Individual and Child coverage on health policy due to _____
If due to death of Insured, Name of New Insured _____
Social Security Number _____ Date of Birth _____
- Add Newborn child (if no underwriting required)
Name of Newborn _____ Sex: Male or Female
Relationship of Dependent to Primary Insured _____
- Reduce the amount of insurance From: _____ To: _____
Basic Policy _____
- Reduce the number of Rider Units From number of Units: _____ To number of Units: _____
Rider Name _____
- Remove the following Benefit Rider _____
- Change Death Benefit Option from 2 to 1 (if changing from 1 to 2, an application must be completed for underwriting purposes)

2. Flexible Premium Payment Changes (FPA or UL only)

- Place policy in non-billing status
- Place policy back in a premium payment status
- Change premium to \$ _____
(Per Month Semi-Annual Annual)
- Make Change Effective _____

3. Application for Duplicate Policy or Certificate

I certify that the above policy has been lost or destroyed and that said policy is not assigned, hypothecated, or pledged in any way whatsoever. I, therefore, request the issuance of a duplicate of said policy and agree that should the original policy be found or in any way come into my possession, I will return or cause the same to be returned to American Heritage Life Insurance Company, its successors or assigns. It is distinctly understood and agreed that the original policy shall become null and void immediately upon issuance of the duplicate policy herein requested. I also agree that if duplicate forms of the lost policy are not available, I will accept a Certificate of Lost Policy.

4. Other Instructions (Be specific)

I agree that my signature below shall apply to each request which has been checked on this form and I further agree that no request will be effective if not checked.

Policy Owner's Signature Required for all Requests _____ Date _____

Joint Owner's Signature _____ Date _____

Note: For Corporate Owner, provide corporation name, two officer's signatures and their titles.

Company Name _____

Officer Signature/Title _____

Officer Signature/Title _____