

# G·T·L

# NON-FINANCIAL

Guarantee Trust Life Insurance Co.

## MULTIPURPOSE POLICY SERVICE FORM

PLEASE PRINT

Date: \_\_\_\_\_

Insured \_\_\_\_\_

Policy No. \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security No. \_\_\_\_\_

Owner \_\_\_\_\_

Owner's Phone Number (\_\_\_\_) \_\_\_\_\_

Mailing Address of Owner \_\_\_\_\_

Number and Street

City

State

Zip Code

Owner's Date of Birth: \_\_\_\_\_

Social Security No. \_\_\_\_\_

Check box if this is a new address

### 1.) Ownership Change: Complete this section if you would like to change the owner of the policy.

\*Note: If the current Owner is deceased, please enclose a copy of the death certificate with this form.

New Owner's Name \_\_\_\_\_

Social Security No. \_\_\_\_\_

Address \_\_\_\_\_

Number and Street

City

State

Zip Code

Date of Birth \_\_\_\_\_

Social Security No. \_\_\_\_\_

### 2.) Correction

Name of Insured \_\_\_\_\_

First Name

Middle Initial

Last Name

Age \_\_\_\_\_

Date of Birth \_\_\_\_\_  
Month Day Year

Male

Female

Your Signature \_\_\_\_\_

Date \_\_\_\_\_

Social Security No. \_\_\_\_\_

OTHER. Indicate here any change not listed on this form:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**3.) Complete this section to add or change a Beneficiary** — I understand that with this change I will terminate all previous beneficiary selections for this policy. The beneficiary selection will be as shown below. You may name more than one Beneficiary.

**Primary Beneficiary**

1.	_____	_____	_____	_____
	Full Name	Address		
1.	_____	_____	_____	_____
	Relationship to Insured	Date of Birth	% of proceeds	Social Security No.
2.	_____	_____	_____	_____
	Full Name	Address		
2.	_____	_____	_____	_____
	Relationship to Insured	Date of Birth	% of proceeds	Social Security No.

**Contingent Beneficiary:** (You may name a contingent who would collect the policy benefits if the primary beneficiary(s) was not living at the time of the Insured's death.)

1.	_____	_____	_____	_____
	Full Name	Address		
1.	_____	_____	_____	_____
	Relationship to Insured	Date of Birth	% of proceeds	Social Security No.
2.	_____	_____	_____	_____
	Full Name	Address		
2.	_____	_____	_____	_____
	Relationship to Insured	Date of Birth	% of proceeds	Social Security No.

Note: If two or more beneficiaries are named above (Primary or Contingent) all surviving beneficiaries will SHARE equally in any payments due, unless the % of proceeds is shown.

\*You have the option to designate your Primary Beneficiary as an Irrevocable Beneficiary. This means the Beneficiary designation could not be changed without Beneficiary's signature.

**4.) This section must be signed by the Policy Owner in order to process your request.**

I agree this form is a request and authorization to change my current policy record.

Date \_\_\_\_\_

Owner's Signature \_\_\_\_\_

New Owner's Signature (if applicable) \_\_\_\_\_

**For Company Use Only:**

The above request for change is acknowledged and has been completed by the Company. This acknowledgment applies only to the policy specified in the form.

Date Completed \_\_\_\_\_ Policy Number \_\_\_\_\_

Signature \_\_\_\_\_