Sagicor

REQUEST FOR CHANGE IN POLICY

POLICY NO.	LIFE INSURED (If other than the policyowner)

NOTE – All the following persons must sign this form

POLICYOWNER	ASSIGNEE, IF ANY
Beneficiaries, If any, who have a vested interest in the policy	
ADDRESS	TELEPHONE NO(S)

- ❑ **Please remove ADB/TD with effect from** _____
- ❑ **Please change mode of payment to** _____ **effective** _____
- ❑ **Please decrease sum assured to** _____ **effective**_____
- ❑ **Please add/remove savings of** _____**(Inclusive of TD – Yes/No)** ____ **effective** _____
- ❑ **Please decrease/increase savings to** _____ **(Inclusive of TD – Yes/No)** _____ **effective** _____
- ❑ **Please decrease/increase premium to** _____ **effective**_____
- ❑ **Others** _____

_____

_____

Sagicor Life Inc is hereby requested to make the above changes for which this shall be good and sufficient authority.

In the case of apparent errors or omissions discovered by Sagicor in the foregoing request, Sagicor is hereby authorized to correct and complete this form and a copy of such amended form will be returned to the policyowner. It is agreed that such changes will have been ratified if the form is not returned within thirty days after receipt thereof.

It is agreed that the original application, the policy and this request shall together form the basis of the contract.

Dated at ……..this……day of ……..……year……..

…….	.....	……..……..……
Witness Signature	Witness Name (Block Letters)	Policyowner
…….	.....	……..……
Witness Signature	Witness Name (Block Letters)	Beneficiaries' signatures
…….	.....	……..……
Witness Signature	Witness Name (Block Letters)	Assignee (if any)