POLICYHOLDER REQUEST CHANGE FORM

Any changes requested on this form must be authorized by the policyholder's signature and date. Premium changes are not to be made by by Payroll Department until adjusted billing is received from Pacific Educators, Inc. this is to request the following:

_____ Change Name From________________________________ To______________________________________

_____ Send Change of Beneficiary Form for ____
(Plan of Insurance)

_____ **Cancel Coverage**

_____ Life Insurance Policy #
_____ Hartford Life _______ ____________ Self
_____ Fidelity Security Life _______ ____________ Spouse
_____ _________________ _______ ____________ Child or Children
_____ Cancer Insurance _______ Names ________________________
____
_____ Income Protection (Disability) Insurance _______ ________________________
_____ Fidelity Security Life - Classified _______
_____ Fidelity Security Life - Certificated _______

_____ **Decrease Coverage**

_____ Life Insurance* Policy #
_____ Hartford Life - Decrease Coverage on Employee from Plan _____ to Plan _____ _______
_____ Hartford Life - Decrease Coverage on Spouse from Plan _____ to Plan______
_____ Fidelity Security Life - Decrease the Following: _______
Coverage on Employee from _____ Units to _____ Units
Coverage on Spouse from _____ Units to _____ Units
Coverage on Children from _____ Units to _____ Units

*Before any decrease can be processed, your existing policy must be attached to this form. If you are unable to locate your existing policy, please check the appropriate box on the "Certificate of Lost or Destroyed Policy" form (see reverse side) and complete this form.

_____ Cancer Insurance From Plan ___________________________ to Plan ____________________________
_____ Income Protection (Disability) Insurance Policy #
_____ Fidelity Security Life - Certificated _______
Decrease Monthly Benefit From $___________ To $___________
_____ Fidelity Security Life - Classified _______
Decrease Monthly Benefit From $___________ To $___________
_____ Change From With Maternity Coverage to Non-Maternity Coverage
_____ Change Elimination Period From __________ Days To ___________ Days
_____ Reduce Benefit Period From 2 Years To 1 Year

School District ____

Name Of Employee ____

Address ____City______________________State_____Zip ________
(Is this an address change? _______)

Date ______________________ **Signature**____

Mail To: Pacific Educators, Inc., P.O. Box 1526, Orange, CA 92856

REQUEST FOR SERVICE
Please complete and return to
PACIFIC EDUCATORS, INC.
2808 E. KATELLA AVE., STE 101
ORANGE, CA 92867

INSURED____

POLICY #____

TYPE OF INSURANCE______________________________________

SCHOOL DISTRICT _______________________________________

ADDRESS / NAME CHANGE

_____ CHANGE ADDRESS TO ____________________________________
Street / P.O. Box / Apt. #

____
City State Zip

_____ CHANGE NAME FROM: ____________________________________

TO ____________________________________

CERTIFICATE OF LOST OR DESTROYED POLICY

_____ I certify that the above mentioned policy has been lost or destroyed and that it has not been assigned, or in any other manner transferred. In consideration of the Company granting the request, I hereby agree to indemnify and hold harmless the Company from any and all losses or injuries which it may incur as a result of granting this request. If the original is found, the duplicate will be returned to Pacific Educators, Inc.

I REQUEST THAT THE ABOVE CHANGES BE MADE

______________________________________ ______________________
SIGNATURE OF OWNER **DATE**