

## INDEPENDENT LIFE INSURANCE COMPANY

P.O. Box 679053 Dallas, Texas 75267-9053

Telephone: (800) 793-0848 Fax: (214) 666-4833

Policy/Contract Number:

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CHANGE OF NAME	ADDRESS REQ	UEST	
ADDRESS CHANGE N	IAME CHANGE B	отн	
1. PAYEE(S) INFORMATION			
NAME EMAIL ADDRESS	SOCIAL SECURITY NUMBER  DATE OF BIRTH  PHONE NUMBER		
2. FORMER NAME AND/OR FORMER ADI	DRESS		
FORMER NAME FORMER STREET ADDRESS			
CITY	STATE	ZIP CODE	
3. NEW NAME AND/OR NEW ADDRESS			
FIRST NAME	LAST NAME		
STREET ADDRESS			
CITY	STATE	ZIP CODE	
4. PAYMENT MAILING ADDRESS (if different	ent from mailing address and paymer	nt is not Direct Deposit)	
FIRST NAME	LAST NAME		
STREET ADDRESS		710 CODE	
CITY	STATE	ZIP CODE	
5. AUTHORIZATION			
I certify that the information on this form	m is accurate and authorize the req	juested change.	

## SIGNATURE OF PAYEE OR LEGAL REPRESENTATIVE

DATE

If individual signing is not the payee, legal documentation must accompany this request if not previously provided. NOTE: Due to schedule of payments these changes may not be reflected for up to 30 days



## 6. INSTRUCTIONS

- 1. Payee Information: Provide all the requested information in this section.
- 2. Former Name And/Or Address Change: If you would like to change your name only, check the "Name Change" box and provide your former name. If you would like to change your address only, check the "Address Change" box and provide your former address. If you would like to change both your name and your address, check the "Both" box and provide your former name and former address.
- 3. New Name And/Or Address Change: If you elected to change your name only, provide your new name in this section. If you elected to change your address only, provide your new address in this section. If you elected to change both your name and your address, enter your new name and new address in this section.
- **4. Payment Mailing Address:** Provide your payment mailing address if you would like to receive your payment at an address other than the address provided in the New Name and/or Address Change section.
- 5. Authorization: Provide your signature and date.

Fax: (214) 666-4833

This form should be printed, completed in full, signed by the payee or legal representative, and then submitted, along with any required legal documents, to Independent Life Insurance Company via email, fax, or mail.

Email: documents@Independent.Life Mail: Independent Life Insurance Company

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