APPLICATION FOR CHANGE IN POLICY

BANK STAMP & SIGNATURE

Policy number	Insured's Name (first, middle initial, last)	Policy Owner's Name (first, middle initial, last)

CHANGE/CORRECT:
- ☐ NAME OF INSURED
- ☐ AGE
- ☐ POSTAL / ST. ADDRESS
- ☐ OWNER

DETAILS OF CHANGE/CORRECTION:

FROM:

TO:

REASON:

☐ CHANGE/CORRECT BENEFICIARY
- ☐ Designated Beneficiary
- ☐ Contingent Beneficiary

For additional beneficiaries and contingent beneficiaries please use page 2.

FROM:	NAME	RELATIONSHIP TO INSURED	D.O.B.	%	REVOCABLE / IRREVOCABLE

TO:	NAME	RELATIONSHIP TO INSURED	D.O.B.	%	REVOCABLE / IRREVOCABLE

CHANGE IN BENEFIT:
☐ ADD ☐ REMOVE

BENEFIT TYPE:
☐ ACCIDENTAL DEATH BENEFIT $_____ ☐ WAIVER OF PREMIUM ☐ OTHER _____

CHANGE IN PLAN:
- ☐ CONVERSION
  - ☐ AT ORIGINAL DATE & AGE
  - ☐ AT CURRENT DATE & AGE
  - ☐ PARTIAL *
  - ☐ FULL
- ☐ REPLACEMENT
- ☐ DECREASE Coverage Amount
- ☐ INCREASE Coverage Amount
- ☐ PAYMENT MODE
- ☐ PAYMENT TYPE **

DETAILS OF CHANGE

	FROM	TO
PLAN		
COVERAGE AMOUNT	**$**	**$**
PREMIUM	**$**	**$**
PAYMENT MODE		
PAYMENT TYPE		

***Partial Conversion – balance of coverage amount is to:** ☐ Remain on original policy ☐ Terminate

** **Please include the appropriate premium payment form.**

EFFECTIVE FOR PREMIUM DUE: _____ of _____/ 20____

☐ REQUEST TO CHANGE SMOKING STATUS

Policy must be in force for no less than one year. Use of tobacco products in any form, must have ceased for no less than 24 consecutive months. Please submit: •Application •Smoker/Non-Smoker Affidavit • NCM Test

☐ REQUEST TO REVIEW RATING

Policy must be in force for no less than one year before rating can be reviewed. The Underwriting Department reserves the right to request additional information and/or evidence necessary to complete their assessment. Please submit: • Application

I agree that these changes shall be an amendment to my original application and further agree that the changes will not be effective until this application is approved by BAF Financial & Insurance (Bahamas) Limited. In the event of request for change in plan or amount, I hereby surrender all my right, title and interest in the policy as written prior to the change herein requested.

Dated at _____ this _____ day of _____ 20_____.

_____
Signature of Insured *(if present age is 16 or older)*

_____
Signature of Original Beneficiary

_____
Signature of Owner

_____
Signature of Original Beneficiary

_____
Witness *(print name and sign)*

_____
Signature of Former Owner *(to be used for change of owner request only)*

Policy number	Insured's Name (first, middle initial, last)	Policy Owner's Name (first, middle initial, last)

CHANGE/CORRECT BENEFICIARY
(Additional Information)
☐ Designated Beneficiary
☐ Contingent Beneficiary

FROM:	NAME	RELATIONSHIP TO INSURED	D.O.B.	%	REVOCABLE / IRREVOCABLE

TO:	NAME	RELATIONSHIP TO INSURED	D.O.B.	%	REVOCABLE / IRREVOCABLE

Affidavit of Loss and Request for Duplicate Policy

I hereby certify that I am the owner of policy _____issued by BAF Financial & Insurance (Bahamas) Limited, that the Beneficiary named in the said policy is _____
_____
_____
and that no person or persons, corporation or association has any claim or interest in said policy by virtue of any sale, assignment or pledge thereof, except as follows:

_____
_____
_____
(Give names and addresses; if no exceptions, insert "NO EXCEPTIONS")

I further certify that said policy is lost and that the circumstances of the loss or destruction were as follows:

_____
_____
(Give full details as to the loss or destruction)

On the basis of the above affidavit, I hereby request that BAF Financial & Insurance (Bahamas) Limited, issue a duplicate of the policy described above, or a certificate of insurance evidence that contract witnessed thereby, said duplicate or certificate to be numbered the same as the original. In consideration of the granting of this request, I undertake and agree as follows:

1. The said duplicate shall stand in the place and stead of the original policy for all purposes.
2. That if the original policy, if later found, the duplicate or certificate shall be returned promptly to the insurer for cancellation and the original returned for endorsement of any policy changes since issuance of the duplicate policy or certificate of insurance.
3. That I will assume all liability for loss or injury to said Company which may occur as direct or indirect result of issuing this duplicate policy or certificate of insurance.

Dated at _____ this _____ day of _____ 20_____.

_____
Signature of Insured *(if present age is 16 or older)*

_____
Signature of Owner

_____
Witness *(print name and sign)*

_____
Signature of Original Beneficiary

_____
Signature of Original Beneficiary

_____
Signature of Former Owner *(to be used for change of owner request only)*