Policy Changes Form

NEW PROVIDENCE
LIFE INSURANCE COMPANY LIMITED

Main Insured

Last Name	First Name	M.I.	Customer ID

Changes

Change Address to:

_____

_____

Change Phone Number to:

Change Email Address to:

Change Payment to:

☐ Semiannual ☐ Monthly
☐ Annual ☐ Payroll Deduction

*Please use your **Customer ID** and **Certificate Number** (previously received upon application submission), to submit method of payment changes in the **Online Payment Portal**.*

Riders:

If you are adding a Rider coverage to the policy, please add the corresponding premium to the renewal payment.

☐ Maternity Rider ☐ Excess Coverage

☐ Prescription Drug Rider ☐ 30-Month Income Protection Rider

☐ Cash Protector Rider ☐ Term Life Rider

☐ Dental, Vision & ADD
(List name of insured[s] purchasing this rider in the space provided below)

Health Policies – Change Deductible:

If you are lowering the deductible, this change is subject to the approval of the Underwriting Department. Therefore, you should attach to the medical questionnaire from the application to this form.

Current Deductible: _____

New Deductible: _____

Disability Policies – Change Coverage Amount:

If you are lowering the deductible, this change is subject to the approval of the Underwriting Department. Therefore, you should attach to this form the medical questionnaire from the application.

Current Coverage Amount: _____

New Coverage Amount: _____

Additional Details:

_____

_____

***Note:** All changes stated on this form can only be effective on the anniversary date of the policy. Please forward to renewals department.*

Main Insured Signature _____ Date _____ /_____ /_____
Day Month Year

❑ For electronic delivery of policy documents, check this box and provide email address below.

Email address: _____

Mail or email completed, signed application to:

New Providence Life Insurance Company Limited
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Tel: (242) 326-6779; (242) 677-6945; (242) 677-6946 • Email: administrator@newprovidencelife.com