



**STATE LIFE**

INSURANCE CORPORATION OF PAKISTAN

Bancassurance Cell  
State life Building No: 9  
Dr. Ziauddin Ahmed Road,  
P.O. Box 5725, Karachi  
Telephone No: 021-99204519

## Amendment To Proposal / Policy Request Form

I, THE UNDERSIGNED, Proposed Assured / Insured Name: \_\_\_\_\_

Owner of Proposal / Policy Number : \_\_\_\_\_ hereby request State Life Insurance Corporation to amend my above life insurance Proposal / Policy as follows:

**Plan Changes**

- |                                                    |                                               |                                      |                                    |
|----------------------------------------------------|-----------------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Increase Sum Assured      | <input type="checkbox"/> Decrease Sum Assured | From _____                           | To _____                           |
| <input type="checkbox"/> Increase Policy Term      | <input type="checkbox"/> Decrease Policy Term | From _____                           | To _____                           |
| <input type="checkbox"/> Change in Mode of Payment | <input type="checkbox"/> Annual               | <input type="checkbox"/> Half Yearly | <input type="checkbox"/> Quarterly |
|                                                    |                                               |                                      | <input type="checkbox"/> Monthly   |

Addition			Deletion		
Rider Name	Sum Assured	Term	Rider Name	Sum Assured	Term
Add <input type="checkbox"/>	Delete <input type="checkbox"/>	<b>Family Income Benefit (Default 10%)</b>		<b>Sum Assured</b>	<b>Percentage</b>
				PKR._____	% _____

Change in Auto Non-Feiture Option       Automatic Premium Loan       Auto Paid Up

Change of Insured Name (for Female only) / Correction in Insured Name

From : \_\_\_\_\_ To: \_\_\_\_\_

- Attach CNIC Copy in support of requested change

**Change of Beneficiary / Contingent Beneficiary**       **Addition of Beneficiary / Contingent Beneficiary**

Full Name of Beneficiary with CNIC Number	Date of Birth	Relation to insured	Share	Address
<b>Guardian in case Beneficiary is Minor)</b>				
Full Name of Guardian with CNIC Number	Date of Birth	Relation to Beneficiary	Address	

**Address Change**

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**Customer Declaration:-**

This is to certify that I am in as good health as when I signed the Personal Statement of Health which consulted a part of my proposal for Insurance to STATE LIFE INSURANCE CORPORATION OF PAKISTAN, and that since the date of such statement there has been no change in my occupation or family record, nor have I had any illness or disease, nor have I consulted or been examined by any Physician, and I have not applied for new Insurance, change in plan or reinstatement which was declined, postponed, withdrawn or modified, in kind or rate and I understand that the issuance or delivery to me of any policy issued on said application and declaration is conditional upon the truth fullness of the above statements. I also understand that any untrue statement would render the life insurance contract null and void and no claim will be payable thereunder.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

\_\_\_\_\_  
**Signature of Life Proposed**

**DSFO:**

Signatures \_\_\_\_\_

\_\_\_\_\_  
**Signature of Proposer  
(if other than Life Proposed)**

Name \_\_\_\_\_

Branch : \_\_\_\_\_