



Nationwide®
is on your side

Life Policy Owner's Service Request
Nationwide Life Insurance Company
Nationwide Life and Annuity Insurance Company
PO Box 182835, Columbus, OH 43218-2835
Phone: 800-848-6331 • Fax: 888-677-7393 • nationwide.com

Please fill out Sections 1 and 9, plus the section(s) that apply to your requested change.

1. General Information (please print)

Owner's Information:

First Name: _____ Last Name: _____ Policy Number: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____

Nationwide strives to provide excellent customer service to our Members. By providing your telephone number, you authorize the Nationwide Family of Companies to contact you via telephone using automated technology to assist you with your account. By providing your email address on this form, you give us permission to communicate with you about this transaction via email.

Insured's Information: ☐ Same as Owner

Name: _____

Joint Owner's Information (if applicable):

Name: _____ SSN: _____

2. Address Change

☐ **Policy Owner:**

Name: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

County: _____

☐ **Primary / Joint / Additional Insured:**

Name: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

County: _____

☐ **Premium Payor:**

Name: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

County: _____

3. Name Changes (this is not an ownership designation form)

Change the name of: ☐ Primary Insured ☐ Payor ☐ Owner ☐ Other (e.g. Joint Insured, Additional Insured)

From former name: _____

To present name: _____

Reason for change: ☐ Marriage ☐ Correction ☐ Divorce ☐ Court Action ☐ Adoption

NOTE: Along with this form, please include a copy (no originals) of the information supporting this change request (e.g., marriage certificate, divorce decree, adoption paperwork, new Social Security card, court order.)

4. Change Dividend Option

FUTURE dividends are to be applied as follows:

- ☐ To accumulate as interest
- ☐ To reduce the Premium
- ☐ To be applied to reduce the loan principal
- ☐ To purchase Paid-Up-Additional Insurance
- ☐ Annual Premium to be paid from dividend value each year
- ☐ Other (be specific): _____

NOTE: Your current dividend balance will remain unchanged.

IMPORTANT INFORMATION CONCERNING BILLING CHANGES IN SECTIONS 5-7: Your policy may not work as originally illustrated if you make changes, such as to your payment frequency, amount, or by stopping payments altogether. Before you make such a change, please contact your financial professional or contact us at 800-848-6331 to request an updated in-force illustration. These types of changes can have a significant impact on your policy value.

5. Stop Recurring Automated Clearing House (ACH) Payments

- ☐ **Stop my recurring ACH payments and bill me directly instead**

If you want your billing frequency to change, complete Change Direct Billing Frequency in Section 6. If you are currently on monthly recurring ACH payments, you must choose a new frequency in the next section or we will default to sending your billing statements quarterly.

- ☐ **Stop my recurring ACH payments and do not send billing statements**

Your ACH payments will be stopped altogether, and you will not receive any billing statements. You will continue to receive quarterly or annual statements, as well as loan interest statements if you have a loan on your policy.

Please provide notification to us at least 10 days in advance of your next ACH payment date. Doing so allows us and your bank to take action. If this request is received less than 10 days from your next payment date, it may be too late to stop the current payment and an additional payment may be taken.

6. Change Billing Frequency (for Direct Bill only)

(Do not use this form to change the frequency of your ACH or bankcard payments.)

If you are stopping your monthly recurring ACH payments and changing to direct bill, please select a new frequency in this section. Otherwise, we will default to sending your billing statements quarterly.

Frequency: ☐ Annual ☐ Semiannual ☐ Quarterly **NOTE:** Monthly is not an option.

You will receive a billing notice within 31 days of the due date.

NOTE: Changing your frequency may require an adjustment payment.

7. Change Amount of Scheduled Premium Payments (for Direct Bill only)

(Do not use this form to change the premium amount for ACH or bankcard payments.)

- ☐ Change the Amount of my Scheduled Premium Payments to: \$_____ (NOTE: Some policy types, such as Term, Whole, or CareMatters, have a predetermined, fixed premium amount that cannot be changed.)

8. State Fraud Disclosures

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

9. Signature(s) (required)

I certify that all of the information I have provided in this form is accurate and true.

Owner:

Name (please print): _____

Signature: _____ Date: _____

Joint Owner (if applicable):

Name (please print): _____

Signature: _____ Date: _____