Request for Service

1. Insured		
Name:		Policy #:
Date of Birth:	SS #:	Current Salary:

2. Contract Owner		
Name:		
Address:		☐ Check here for change of address
City:	State:	Zip Code:

3. Name Change (Please Print)	
Change Name of: ☐ Insured ☐ Owner	
From (Former Name):	To (New Name):
Reason For Name Change: ☐ Marriage ☐ Divorce or resumption of former name ☐ Other:	
Please sign this form using your NEW name	

4. Premium/Billing Changes
☐ Change Planned Periodic Payments to:

5. Increase/Decrease in Benefits
☐ Increase/Decrease Face Amount to:

6. Request Duplicate Policy/Certificate (Original was lost)
☐ Please send me a Confirmation of Insurance Coverage at no charge.
☐ Please send me a complete Duplicate Certificate *(Please enclose $25 handling fee with this request)*

7. Other Changes/Comments

Owner's Signature:____ Date:______________________

Please return form to:
Univers Workplace Solutions
WrapPlan®II Administrator
1060 Maitland Center Commons Suite 210
Maitland, FL 32751