

# Ownership Change Request Form



Established 1896

Innovation is Our Policy

Fidelity Life Association  
P.O. Box 5030  
Des Plaines, IL 60017  
Tel (800) 369-3990  
Fax (866) 947-8738

Policy Number: \_\_\_\_\_

Owner: \_\_\_\_\_

Owner's Social Security Number: \_\_\_\_\_

Insured: \_\_\_\_\_

Owner's Phone Number: \_\_\_\_\_  
(including area code)

Ownership Change: Check One:  Owner  Joint Owner

If new owner is an individual, is owner a United States citizen?  Yes  No

If NO, please provide:

Country of Origin: \_\_\_\_\_ Passport number and country of issuance: \_\_\_\_\_

Alien identification number of other number of government issued identification: \_\_\_\_\_ Country of Issuance: \_\_\_\_\_

\_\_\_\_\_  
Name of New Owner

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Daytime Phone Number of New Owner

\_\_\_\_\_  
Social Security/Tax I.D. Number  
of New Owner

\_\_\_\_\_  
Date of Birth

- If multiple owners are being requested, only one mailing address and taxpayer ID or social security number will be recorded of billing purposes. However, please indicate any additional co-owner(s) in Special Instructions below.
- Assuming this form is in good order, the new ownership designation cancels all previous designations.
- The new address will replace the existing address on record for the owner only.
- Both of the existing owner(s) and the new owner(s) must sign in the Signatures section below.
- **Ownership change to a trust** – include the name and date of the trust, the trustee's name, and taxpayer ID number of the trust. The trustee must then also sign below in the Signatures section as the New Owner. Also the first page and the signature page of the trust agreement must be attached to this form.
- **Ownership change to a partnership** – all partners must sign including their title.
- A change of ownership may have tax consequences. The Company suggests you consult an attorney, accountant, or tax advisor for more information.

## Secondary Address (if needed to receive duplicate copies of billing correspondence)

\_\_\_\_\_  
Secondary Addressee Name (please print)

\_\_\_\_\_  
Daytime Phone #

\_\_\_\_\_  
Secondary Addressee Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

