CICA LIFE
A CITIZENS COMPANY

Additions and Reductions of the policy

Return completed form to
PHS@citizensinc.com
or Fax: 512.836.9785
*Unless otherwise specified

Policy Number:	Insured:	Owner:	Owner's ID #:

Current Address:	Taxpayer Reference Number:

Owner's Email:	Owner's Phone #:	Owner's Date of Birth:	Insured's Date of Birth:	Date:

REFER TO REVERSE SIDE FOR ADDITIONAL INSTRUCTIONS

----------Include a copy of your official ID – Please send form for all of these requests through email----------

☐ 1. PLAN AMOUNT

☐ Reduce amount ☐ Convert policy ☐ Convert rider

Amount to be issued $_____

Premium to be paid ☐ annually ☐ semiannually ☐ quarterly ☐ other _____
Automatic premium loan provision ☐ is ☐ is not desired, if available
If participating, option desired is ☐ applied to premium ☐ paid up additions ☐ deposit at interest ☐ paid in cash

☐ 2. BENEFITS RIDERS

SUPPLEMENTAL BENEFITS AND RIDERS

	ADD	REMOVE
Waiver of Premium Disability	☐	☐
Accidental Death	☐	☐
Accidental Death and Dismemberment	☐	☐
Triple Indemnity	☐	☐
Beneficiary Accidental Death Benefit (BADB)	☐	☐

	ADD	REMOVE
Expanded Coverage (ECE)	☐	☐
Decreasing Term US_____ years	☐	☐ Level
Term US$_____years	☐	☐ Other
_____	☐	☐

☐ 3. OTHER CHANGES

☐ Review for removal or reduction of rating (extra Premium)
☐ Increase APB to_____units
☐ Reduce APB to_____units
☐ Add Advanced Premium Payment Fund for $_____/ years. **Surrender charges may apply.
☐ Add Annuity Fund for $_____ Programmable ☐ Non-Programmable ☐
☐ Other (Specify) _____

It is understood and agreed that this "Application for Policy Change and/or Endorsement" shall become a part of the policy and constitute a single and entire contract of insurance. THE FOLLOWING APPLIES TO CHANGES REQUESTED WHICH ARE NOT GUARANTEED AVAILABLE UNDER THE ORIGINAL POLICY: It is understood and agreed that: **(1)** the requested changes in the above referenced policy shall not become effective until and unless they are approved by the Company in writing and that when so approved, this "Application for Policy Change and/or Endorsement" shall become a part of the policy and constitute a single and entire contract of insurance; **(2)** any such changes shall be subject to the provisions and conditions of the policy; **(3)** the Company may require evidence of insurability satisfactory to it; **(4)** payment of any premiums and any other consideration due for such changes must be received in full at the Executive Office of the Company while the insured is in good health; and **(5)** the Company may require the receipt of the policy and any additional information requested before any change is effective.

Dated at_____this_____day of_____, of 20____.

_____ _____
Witness **Signature of Insured or Owner if other than Insured**

THE UNDERSIGNED AGREES TO THE ABOVE REQUEST AND CHANGES

_____ _____
Signature of Assignee (if any) **Signature of Irrevocable Beneficiary (if any)**

----------FOR HOME OFFICE USE ONLY----------

ACKNOWLEDGMENT OF POLICY CHANGE – PLEASE ATTACH TO POLICY
CICA LIFE INSURANCE COMPANY OF AMERICA has recorded the change requested and retained a photocopy of the request.

DATED at Austin, Texas _____Approved by _____

The following policy specification changes are effective with this endorsement as a result of the changes requested above:
☐Issue Date_____ ☐Issue age_____ ☐Paid to date _____
☐Premium: Annually US$_____Semi-annually US$_____Quarterly US$_____Monthly US$_____
Special Monthly US$ _____.
☐Other Home Office Endorsements: _____.

**The original Table of Guaranteed Values has been changed to reflect values that coincide with the specific changes requested and approved herein.

ADDITIONAL INSTRUCTIONS

****Please use separate forms for each separate insured. Complete questions 4 through 25 for the following:**

CONVERT IN PLAN OR CHANGE AMOUNT: **(1)** Conversion of a term policy or rider to permanent insurance, if term policy contained benefits (W .P.; D. I.; etc.) and the s ame benefits will be retained with the new policy; **(2)** Change to lower premium plan of permanent insurance for same or lesser amount and present age and amount are within non-medical limits (furnish medical examination, at insured's expense, if present age and amount are not within regular non -medical limits); **(3)** change to higher premium plan if benefits are to be retained from the original policy.

ADDITION OR DELETION OF BENEFITS OR RIDERS: Use only if adding a benefit or term rider, Medical examination, at insured's expense, is also required if: **(1)** Waiver of premium disability is to be added and attained age is 41 or over or amount of premium to be waived exceeds $500.00 annually; **(2)** pay or benefits are to be added and it does not f all within non-medical limits as to age and amount.

OTHER CHANGES: Indicate reason for the change below if the rules of the Company require evidence of insurability such as: Review of rating; Change accumulations to paid up additions. Also, in some instances to correct the age if the risk is increased. For beneficiary, owner, name or non-forfeiture changes, use "Policy Owner's Change Request" Form.

4. Insured or Owner (applicable to the requested changes):	**Policy Number:**	**5. Date of Birth:**
6. Reason for this application (see instructions):	7. Amount accidental death benefit now in force in all companies (if applied for) US $_____	

Answer questions 9 through 25 if non-medical evidence of insurability is required – See Instructions.

8. Present occupation and duties of Insured(s). Time in present occupation _____Years

9. Does any Insured have a current aviation license or does any Insured intend to fly or has anyone flow n in the past three years as a student pilot, pilot or crew member or with any duties aboard any aircraft while in flight (including flight to qualify for flight pay)? If "yes" complete "Aviation Supplement." YES ❒ NO ❒

10. a. Height_____ft. b. Weight _____lbs.

11. Has any Insured had an application for insurance issued with an extra premium or other than as applied? YES ❒ NO ❒

12. Does any Insured have any other application for insurance pending? If so, give amounts and companies below. YES ❒ NO ❒

13. Within the past 10 years, has any Insured taken any special tests such as electrocardiogram, blood sugar, basal metabolism, or X- ray? YES ❒ NO ❒

14. Within the past 10 years, has any Insured had a surgical operation? YES ❒ NO ❒

15. Within the past 10 years, has any Insured been advised to have a surgical operation not performed? YES ❒ NO ❒

16. Has any Insured been given a medical discharge or been declined for military service because of physical or mental reasons? YES ❒ NO ❒

17. Within the past 10 years, has any Insured taken any drug for the reduction of blood pressure, for chest pain or for sugar in the urine? YES ❒ NO ❒

18. Does any Insured now have or has any Insured within the past 10 years had?
   a. Asthma, spitting of blood, habitual cough, pleurisy or tuberculosis? YES ❒ NO ❒
   b. Rheumatism, arthritis, diabetes, cancer or other tumors? YES ❒ NO ❒
   c. Dizzy spells, convulsions paralysis, unconsciousness, nervous or mental trouble or any disease of the brain or nervous system? YES ❒ NO ❒
   d. Albumin, sugar casts, pus or blood in the urine, any kidney disease, or any disease of the urinary system? YES ❒ NO ❒
   e. Disease of the stomach, intestines, gallbladder, ulcer, indigestion, or other disease of the digestive tract? YES ❒ NO ❒

19. Within the past 5 years, has any Insured consulted any physician or been confined to any hospital, clinic or rest home not mentioned above? YES ❒ NO ❒

20. Does any Insured now have any physical defect, disease or symptom not mentioned above? YES ❒ NO ❒

21. Within the past 10 years, has any Insured had any serious illness, disease or injury not mentioned above? YES ❒ NO ❒

23. Is any Insured now_____ pregnant? How Long? _____months. YES ❒ NO ❒

22. Within the past 10 years, has any Insured had any disease or disorder of the reproductive organs including prostate, uterus, etc.? YES ❒ NO ❒

24. Has any Insured been diagnosed or treated by a medical practitioner for AIDS (Acquired Immune Deficiency Syndrome), positive HIV test or any other immunological disorder? YES ❒ NO ❒

25. If any questions from 12 through 25 have been answered "Yes," list question number and give details below (or on another sheet if necessary) including dates, names, and addresses of all physicians, etc. GIVE FULL MEDICAL HISTORY ON THIS FORM. DO NOT REFER TO PREVIOUS APPLICATIONS

For Home Office endorsement only. Statement No. _____corrected as follows:	Date received in Home Office:

I represent that the above statements and answers are full, complete and true to the best of my know ledge and belief and agree that this application with any other declarations of insurability submitted to the Company shall be considered an amendment to the original application and shall become a part of the policy and constitute a single and entire contract of insurance.

It is understood and agreed that reinstatement of the policy is based on statements in this application and shall be contestable, for misrepresentation of any material facts stated therein or in connection therewith, for two years from date of reinstatement; however, if the incontestable period provided in the original policy has not expired, the Company does not waive its rights thereunder. If reinstatement is not approved, any amount paid herewith will be void.

AUTHORIZATION

By this form (or a photographic copy of it), I authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other person, organization, or institution, that has any records or know ledge of me or my child for whom insurance application is made or my health or my child's health, to give the Company, or its reinsurers, any such information and to testify as to such information. This authorization is effective for 24 months from the date below and may be revoked by writing to the Company's policy service department.

Dated at_____this_____day of_____of 20_____.

Signature ofWitness _____ _____

Signature of Insured (Parent if juvenile policy)

Printed Witness Name _____ _____

Signature of Owner, if other than Insured