Name Change Request

AccordiaLife
www.accordia.com

Mail or fax completed form to:
PO Box 305027, Nashville, TN 37230-5027
Fax: 800 351 0603

Contact us:
Customer Contact Center – Tel: 877 462 8992

Accordia Life and Annuity Company
215 10th Street, Suite 1100, Des Moines, IA 50309

First Allmerica Financial Life Insurance Company
132 Turnpike Road, Suite 210, Southborough, MA 01772

1. INFORMATION ABOUT THE OWNER

First Name	M.I.	Last Name	Suffix
Policy / Contract Number(s)			

Mailing Address	City	State	Zip	Country
Street Address (**REQUIRED** if mailing address is a PO Box)	City	State	Zip	Country

Social Security Number (last four digits) X X X - X X -	Date of Birth (mm/dd/yy) / /	Email Address

Personal Phone ( ) -	Business Phone ( ) -	☐ Address Change Requested (Confirmation of this change will be sent to you prior to processing this request.)

2. NAME CHANGE

Change the Name Of: ☐ Insured/Annuitant ☐ Owner ☐ Other (Payor): _____

Former Name (Please print)	New Name (Please print)

Reason for Change: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Other: _____

NOTE: For name changes due to marriage, attach a copy of the marriage certificate. For all other name changes, attach the legal supporting documentation.

3. YOUR CONFIRMATION

By signing below, I acknowledge this request is subject to the provisions and conditions of my policy/contract(s) and the company may request additional information in order for my request to be processed.

Owner Signature X	Owner's Title (if Trust or Corporation)	Date (mm/dd/yy) / /
Joint Owner Signature (if applicable) X	Print Name	Date (mm/dd/yy) / /

If you are signing on behalf of the owner, please print your name and provide your signature below. Check the box that applies to the capacity in which you are signing. If you have not already done so, please provide your Power of Attorney, Conservatorship, or Guardianship documents to verify you are authorized to act on behalf of the owner.

☐ Conservator ☐ Guardian ☐ Power of Attorney ☐ Assignee

Signature (if applicable) X	Print Name	Date (mm/dd/yy) / /

We appreciate your business and are committed to providing you with accurate and caring service. If you have any questions or need additional information, contact your Insurance Professional or our Contact Center.