StateFarm

☐ **State Farm Life Insurance Company** (Not licensed in MA, NY or WI)
Home Office, Bloomington, IL 61710

☐ **State Farm Life and Accident Assurance Company** (Licensed in NY or WI)
Home Office, Bloomington, IL 61710

Request Letter

This Request Letter is a convenient way to request a change in your life insurance policy and/or the related office records. If you are contemplating any change in your policy, we strongly urge that you first **contact your State Farm® agent** who will be happy to assist you.

If, for any reason, a State Farm agent is unavailable, you may initiate such a change by completing this Request Letter in accordance with its instructions. This form is in six parts: Part (A) should be completed to withdraw values from your non-tax qualified life policy; Part (B) should be completed to withdraw values from your annuity or tax-qualified life policy (some exceptions apply); Part (C) should be completed to make other changes with regard to your life policy, such as dividend option change or mode change; Part (D) should be completed to convert your term insurance policy or rider; Part (E) should be completed to request a change of beneficiary; Part (F) should be completed to electronically transfer money from your State Farm life policy to a bank account. These forms are to be sent to the Life Operation where your policy is serviced. **DO NOT SUBMIT YOUR POLICY UNLESS REQUESTED**

IF YOU ARE EVER ADVISED TO REPLACE YOUR STATE FARM POLICY - PLEASE:

1. Contact your State Farm agent. It is seldom in your best interest to change from one life insurance policy to another.

2. Request the advising agent to complete comparison forms for your signature. (If applicable in your state.)

3. Ask the advising agent to read and sign the statement below and return it to your State Farm agent.

Advising agent - hereby advise this State Farm policyowner to discontinue his/her policy and replace it with one from the:

_____ Company

Signed _____

Insured's Name _____ Policy Number _____

Part (A) Policy Values (Non-Tax Qualified Life Policies) *Do not use this for Annuities or TQ Policies*.

To: ◯ State Farm Life Insurance Company ◯ State Farm Life and Accident Assurance Company

Re: Policy Numbers _____ Name of Insured _____

☐ **Accumulated Dividend Withdrawal -** Withdraw and pay to me dividend values of $ _____ or the total if less.

☐ **Surrender of Paid-up Dividend Additions -** Withdraw and pay to me dividend values of $ _____ or the total if less.

☐ **Universal Life Partial Withdrawal -** Make a partial withdrawal of $ _____ ($500.00 minimum).

☐ **Policy Loan -** I assign the policy to you as security for this loan and for the interest which will accrue from the effective date of the loan.

- ☐ Make a policy loan of $ _____ or the maximum loan value if less. Add to the loan any premium currently billed and not paid.
- ☐ Make a policy loan to pay the premium currently billed and not paid.
- ☐ Include $ _____ ($15.00 minimum) in each premium billing to be applied as a loan repayment.
- ☐ Include $ _____ ($15.00 minimum) billable loan repayment on Pre-Authorized Collection Plan. *Complete an authorization form.*

☐ **Termination/Cash Surrender -** Terminate my policy coverage and pay all termination/cash surrender values to me. Please waive any requirement for surrender of the policy to the Company. I understand my policy cannot be reinstated in the future.

PLEASE NOTE: Once processed, disbursements cannot be reversed. Any tax reportable gain realized when policy values are released (or transferred to another policy) cannot be changed.

Indicate Payment Method: (Check is the automatic option if no option is selected)

◯ Electronic transfer to external bank. Bank Name _____ Account # _____

Complete Part F form and attach voided check for checking account or deposit slip for savings account. Accountholder names on the check/slip must be pre-printed (not handwritten).

◯ Electronic transfer to State Farm Bank®. Account # _____ *($100.00 minimum for 1 year Tax Qualified CD)*

If State Farm Bank account is Tax Qualified, please indicate: ◯ *Current Tax Year* ◯ *Prior Tax Year*

◯ Transfer to State Farm Mutual Funds® Account # _____ Fund # _____ *($50.00 minimum)*

If State Farm Mutual Funds account is Tax Qualified, please indicate: ◯ *Current Tax Year* ◯ *Prior Tax Year*

IMPORTANT NOTICE OF WITHHOLDING AND ELECTION Substitute Form W-4P/OMB No 1545-0415 - *(Not applicable in Canada.)*
The taxable portion of proceeds may be subject to federal and state (if applicable) income tax withholding. If we do not have your taxpayer identification number, withholding will occur. By your election, you may be responsible for payment of estimated taxes; and there may be tax penalties if your withholding and estimated payments are not sufficient. **Your withholding election is final and cannot be changed after the transaction is processed.**
Federal Income Tax Withholding - If you have provided your taxpayer identification number, you may elect not to have federal withholding apply by checking the proper box below. **If a box is not checked or if we do not have your taxpayer identification number, federal tax will be withheld at a rate of 10% as required by law.**

◯ I do not want federal income tax withheld. ◯ Withhold federal income tax at a rate of _____ % (not less than 10%).

◯ Withhold federal income tax of $ _____ in addition to the base withholding of 10%.

State Income Tax Withholding - We will only withhold if you live in a state that requires us to withhold. We will withhold at least the minimum amount required by your state. If you would like us to withhold more than the minimum amount, please indicate so below.

◯ I do not want state income tax withheld. I understand this election will not apply in states that do not permit persons to elect out of withholding.

◯ Withhold my state's minimum required percentage. If you live in a state that does not specify a percentage, we will not withhold.

◯ Withhold state taxes according to the following: $ _____. I understand that I cannot request withholding in an amount less than my state's minimum amount.

☐ **Change Mail Address to:** For _____ Policyowner's Telephone Number _____

(Street) (City) (State) (ZIP Code)

☐ **Change Name of:** _____ **from** _____

(Policy Role) (Print Old Name)

to _____ **due to** _____

(Print New Name) (Reason for Change)

The legal name must be provided. If the name of the Policyowner is being changed, sign the new name as "Signature of Policyowner" below.

☐ **Add Successor Owner/Purchaser** _____ ☐ **Extend Ownership Control to Age** _____

(Name of Successor Owner/Purchaser)

☐ **Change Ownership to** _____ _____

(New Owner's Name) (New Owner's Signature)

_____ _____

(New Owner's Address) (New Owner's Social Security Number)

ALL OTHER OWNERSHIP PROVISIONS AND RIGHTS WILL REMAIN THE SAME UNLESS SPECIFICALLY CHANGED. If the policy requires endorsement, mailing to the new owner an acknowledgment of the ownership change will serve as the endorsement.

☐ **Other**

Signature of Policyowner _____ Date _____

Signature of Agent as Witness (Not Required) _____ Date _____

Agent's Code Stamp

Part (B) Policy Values (Annuities and Tax Qualified Policies) *Do not use this for non-TQ Life Policies.*

To: ◯ State Farm Life Insurance Company ◯ State Farm Life and Accident Assurance Company

Re: Policy Numbers _____ Name of Insured _____

☐ **Change Mail Address to:** For _____ Policyowner's Telephone Number _____

_____ _____ _____ _____

(Street) (City) (State) (ZIP Code)

☐ **Change Name of:** _____ **from** _____

(Policy Role) (Print Old Name)

to _____ **due to** _____

(Print New Name) (Reason for Change)

The legal name must be provided. If the name of the Policyowner is being changed, sign the new name as "Signature of Policyowner" below.

☐ **Add Successor Owner/Purchaser** _____ ☐ **Extend Ownership Control to Age** _____

(Name of Successor Owner/Purchaser)

☐ **Change Ownership to** _____ _____

(New Owner's Name) (New Owner's Signature)

_____ _____

(New Owner's Address) (New Owner's Social Security Number)

ALL OTHER OWNERSHIP PROVISIONS AND RIGHTS WILL REMAIN THE SAME UNLESS SPECIFICALLY CHANGED. If the policy requires endorsement, mailing to the new owner an acknowledgment of the ownership change will serve as the endorsement.

☐ **Future Income Plus Renewal (Deferred Fixed Annuity - DFA) -** During the 30-day window, you have the option to select a new guarantee period (options vary by state). If no option is selected, your policy will automatically renew at the previously selected period; if this option is not available, the next shortest guarantee period will be assigned.

Please renew my guarantee period for**:**

◯ Renew at my previous guarantee period ◯ 7 Year Guarantee Period

◯ 3 Year Guarantee Period ◯ 10 Year Guarantee Period

◯ 5 Year Guarantee Period

☐ **Annuity and Tax Qualified Policy Distributions:** A premature distribution from a qualified retirement plan may be taxed as income and may be assessed a penalty tax by the Internal Revenue Service. **NOTE:** For ROTH IRA withdrawals, you must elect out of withholding below to avoid having income taxes withheld.

☐ Make a partial withdrawal of $ _____. **(<u>If this policy is part of a TSA, Keogh or Corporation Retirement plan, do not use this form. Contact your Life Operation.</u>)**

☐ Make a loan of $ _____ or the maximum loan value if less.

☐ Cash surrender. (If this policy is part of a TSA, Keogh or Corporate Retirement plan, do not use this form. Contact your Life Operation.)

☐ Make a dividend withdrawal of $ _____ or the total if less.

☐ Surrender of paid-up dividend additions - Withdraw and pay to me dividend values of $ _____ or the total if less.

If the surrender value of this policy will be used to fund a non-State Farm retirement or non-Tax Qualified plan, you will be required to provide properly completed transfer/rollover or 1035 Exchange forms along with the name and address of the external company.

PLEASE NOTE: Any tax reportable gain realized when annuity or policy values are released cannot be changed.

Indicate Payment Method: ◯ Check *(this is the automatic option if none is selected)* ◯ Other *(provide instructions below)*

For an electronic funds transfer, complete Part F form and attach voided check for checking account or deposit slip for savings account. Account holder names on the check/slip must be pre-printed (not handwritten).

IMPORTANT NOTICE OF WITHHOLDING AND ELECTION Substitute Form W-4P/OMB No 1545-0415 - *(Not applicable in Canada.)* The taxable portion of proceeds may be subject to federal and state (if applicable) income tax withholding. If we do not have your taxpayer identification number, withholding will occur. By your election, you may be responsible for payment of estimated taxes; and there may be tax penalties if your withholding and estimated payments are not sufficient. **Your withholding election is final and cannot be changed after the transaction is processed.**

Federal Income Tax Withholding - If you have provided your taxpayer identification number, you may elect not to have federal withholding apply by checking the proper box below. **If a box is not checked or if we do not have your taxpayer identification number, federal tax will be withheld at a rate of 10% as required by law.**

◯ I do not want federal income tax withheld. ◯ Withhold federal income tax at a rate of _____ % (not less than 10%).

◯ Withhold federal income tax of $ _____ in addition to the base withholding of 10%.

State Income Tax Withholding - We will only withhold if you live in a state that requires us to withhold. We will withhold at least the minimum amount required by your state. If you would like us to withhold more than the minimum amount, please indicate so below.

◯ I do not want state income tax withheld. I understand this election will not apply in states that do not permit persons to elect out of withholding.

◯ Withhold my state's minimum required percentage. If you live in a state that does not specify a percentage, we will not withhold.

◯ Withhold state taxes according to the following: $ _____. I understand that I cannot request withholding in an amount less than my state's minimum amount.

☐ **Other**

Signature of Policyowner _____ Date _____

Signature of Agent as Witness (Not Required) _____ Date _____

Agent's Code Stamp

Part (C) Policy Changes

To: ◯ State Farm Life Insurance Company ◯ State Farm Life and Accident Assurance Company

Re: Policy Numbers _____ Name of Insured _____

☐ **Change Mail Address to:** For _____ ▼ Policyowner's Telephone Number _____

_____ _____ _____ _____

(Street) (City) (State) (ZIP Code)

☐ **Change Mode of Premium Payment to:**

◯ Annually ◯ Semi-Annually ◯ Special Monthly

◯ Monthly ◯ Quarterly _____ ▼ (Type)

☐ **Premium Offset** ◯ Add ◯ Remove

To add, mode of payment must be Annual and dividend option must be Accumulate or Paid-up Additions. If not, change mode of payment and dividend option.

☐ **Change Dividend Option to:**

◯ Accumulate ◯ Paid in Cash ◯ Paid-up Additions ◯ Reduce Premium

☐ **Change Name of:** _____ ▼ **from** _____

(Policy Role) (Print Old Name)

to _____ **due to** _____ ▼

(Print New Name) (Reason for Change)

The legal name must be provided. If the name of the Policyowner is being changed, sign the new name as "Signature of Policyowner" below.

☐ **Add Successor Owner/Purchaser** _____ ☐ **Extend Ownership Control to Age** _____

(Name of Successor Owner/Purchaser)

☐ **Change Ownership to** _____ _____

(New Owner's Name) (New Owner's Signature)

_____ _____

(New Owner's Address) (New Owner's Social Security Number)

ALL OTHER OWNERSHIP PROVISIONS AND RIGHTS WILL REMAIN THE SAME UNLESS SPECIFICALLY CHANGED. If the policy requires endorsement, mailing to the new owner an acknowledgment of the ownership change will serve as the endorsement.

☐ **Elect Non-Forfeiture Policy Provisions:**

☐ Add Automatic Premium Loan (APL) provision, if applicable.

☐ Add Credits to Avoid Lapse (CAL) provision, if applicable.

☐ **Reconsider Tobacco-use Rating:**

In the past 12 months, have you used tobacco, or any other nicotine products? **PI** ◯ Yes ◯ No **AI** ◯ Yes ◯ No

_____ _____

(Signature of Insured if Different than Policyowner) (Signature of Additional Insured)

☐ **Universal Life/Second to Die/Survivorship Universal Life/Joint Universal Life Only:**

☐ Change Death Benefit Option to: Option 1 ◯ Option 2 ◯

☐ Change Planned Premium to: _____

(Amount of New Planned Premium)

☐ **Cancel Benefit or Rider (Use Part A if terminating entire policy.)**

☐ Cancel _____ If removing CTR, what is the youngest child's date of birth? _____

(Coverage Name and Amount) (Date of Birth)

I understand riders/benefits cannot be reinstated. (Value Earning Policies)

☐ **Decrease Coverage** _____ to _____ Coverage cannot be reinstated or added back to the original policy (Value Earning Policies)

(Base Policy or Rider Name) (Amount)

☐ **Other**

Signature of Policyowner _____ Date _____ Signature of Agent as Witness (Not Required) _____ Date _____	Agent's Code Stamp

State Farm Life Insurance Company (Not Licensed in MA, NY, or WI)
State Farm Life and Accident Assurance Company (Licensed in NY and WI)
One State Farm Plaza, Bloomington, IL 61710-001

Doc Type: **01** Check Digit
Doc Code 01 Subtype 3

Life Term Conversion

Policy Number(s): _____ Name of Insured: _____

CONVERT _____ to _____
(Plan and Amount - Old Policy) (Plan and Amount - New Policy)

Conversion to Universal Life Only
◯ Cash Value Accumulation Test ◯ Guideline Premium Test
◯ Option 1 ◯ Option 2 Planned Premium $ _____

Note: *The new policy will be issued with any rating or exclusions that were present on the original policy prior to the conversion.*

If partial conversion, how should remaining coverage be handled? _____
Converted coverage cannot be reinstated. (Value Earning Policies)

Riders to be transferred: *(if eligible)*

☐ Children's Term Rider (CTR) $ _____

☐ Guaranteed Insurability Option (GIO) $ _____

☐ WPD / WMD

WPD / WMD:
Is the Principal Insured currently disabled? ◯ Yes ◯ No

APL / CAL: *(not applicable to Universal Life)*
APL Provision elected, if applicable? ◯ Yes ◯ No
CAL Provision elected? (NY only) ◯ Yes ◯ No

TOBACCO USE:
In the past 12 months, have you used tobacco, or any other nicotine products? ◯ Yes ◯ No

OWNERSHIP:
Change Ownership to _____
New Owner's Name

_____ _____ _____ _____
New Owner's Address City State ZIP Code New Owner's Social Security Number

Note: *For partial conversions, ownership of the remaining coverage on the original policy is unchanged by this request.*

DIVIDEND OPTION *(not applicable for Universal Life)* ◯ Accumulate ◯ Paid in Cash ◯ Paid-up Additions ◯ Reduce Premium

MODE OF PREMIUM PAYMENT ◯ Annually ◯ Semi-Annually ◯ Quarterly ◯ Special Monthly _____

SFPP Account Number _____

ADDITIONAL INSURED OR CHILDREN'S TERM RIDER CONVERSIONS *(Complete Tobacco Use, Ownership, Dividend Option and Mode of Premium Payment questions).*

Is this a conversion of an Additional Insured's Rider? ◯ Yes ◯ No *Converted coverage cannot be reinstated. (Value Earning Policies)*

Who will own the new policy? _____

Is this a conversion of Children's Term Rider? ◯ Yes ◯ No

Who will own the new policy? _____

Will CTR remain in force after the conversion? ◯ Yes ◯ No (If removing CTR coverage, complete Cancel Benefit or Rider section on Part C.)

Basic Information: *(Complete this information for CTR Conversions only)*

Name of Insured _____ Sex ◯ M ◯ F Date of Birth _____ Age _____

_____ _____ _____ _____
Address City State ZIP Code

Explanations:

If space below is insufficient, use additional sheets which will be part of this application. Sheets must be signed and dated by Proposed Insureds, and/or Applicant, and witnessed.

Signatures Needed: The Original Policyowner's signature is required. If the new policy will be owned by someone other than the Original Policyowner, the New Policyowner should sign all other required forms.

Principal Insured's signature is required when a change of tobacco rating is requested.

Additional Insured's signature is required when AI's coverage is being converted AND a change of tobacco rating is requested.

Children's Term Rider Purchase Option at age 18 - The Original Policyholder's signature is required.

Children's Term Rider Conversion at age 25 - The insured child's signature (as Principal Insured) is required.

Signature of Original Policyowner _____ Date _____

Signature of Principal Insured _____ Date _____

Signature of Additional Insured _____ Date _____

Signature of Agent as Witness _____ Date _____

Agent's Code Stamp

Part (E)

Doc Type: **39**

Change of Beneficiary

A separate form is required for each insured person whose beneficiary is to be changed.

To: ◯ State Farm Life Insurance Company ◯ State Farm Life and Accident Assurance Company

Re: Policy Numbers _____ Name of Insured _____

This change is applied to:

◯ Principal Insured ◯ Additional Insured Name of Additional Insured _____

I request payment of any sum payable on the insured person's death be made as shown below. Payment will be subject to any assignment. Any prior provisions for payment upon the insured person's death are revoked, when this request is recorded. For Additional Insured's or Children's rider, the rider's beneficiary provisions are revoked, and the policy's beneficiary provisions will control. "Additional Insured", "Insured Child", or "Annuitant", will be used in place of "Insured".

COMPLETE SECTIONS FOR ALL BENEFICIARIES, EVEN IF UNCHANGED, GIVING THE FULL NAME, DATE OF BIRTH, ADDRESS (if different from the Insured's) AND RELATIONSHIP TO THE INSURED PERSON FOR EACH. NEW YORK ONLY: ALSO PROVIDE THE PREFERRED TELEPHONE NUMBER AND TAXPAYER IDENTIFICATION NUMBER (SSN/ITIN/TIN) FOR EACH BENEFICIARY. ***Please type or print in ink and initial any cross-outs.***

Beneficiaries

Primary - Name, Date of Birth, Relationship, Address

Successor - Name, Date of Birth, Relationship, Address

Unless changed by this request:

- Two or more surviving beneficiaries of a class will share equally.
- If children of a person are named as a class, only children born to or legally adopted by that person will be included as beneficiaries.
- Any beneficiary to whom "time clause" applies will be deemed not to have survived the insured person if that beneficiary is not living on the 30th day after insured person's death.

Special Provisions: The Company will not be responsible for use of any sum payable by a trustee or authorized representative of a beneficiary. Payment to a trustee or authorized representative of a beneficiary will fully discharge all liability of the Company to the extent of such payment.

- If a trust is not in force, or if qualifying conditions for trust under will are not met, payment will be made to the succeeding beneficiary, if any.
- Qualifying Conditions for Trust under Will. The Will must be admitted to Probate within 180 days after insured person's death, and trustee must qualify within 1 year after insured person's death.

The change will take effect in accordance with policy provisions, but the change will not affect any action we may have taken before we receive the request. If the policy requires endorsement, mailing an acknowledgment of the beneficiary change to me will serve as the endorsement.

Signature of Policyowner _____ Date _____

_____ _____ _____

City State ZIP Code

Signature of Witness _____ Date _____

Agent's Code Stamp

Part (F)

Doc Type: **55**

Electronic Funds Transfer Bank Account

To: ◯ State Farm Life Insurance Company ◯ State Farm Life and Accident Assurance Company

Re: Policy Number _____ Name of Insured _____

Complete this form to electronically transfer money from your State Farm life insurance policy to a bank account. Do not use this form for Universal Life Flexible Care Benefit (UL FCB) payments. Your financial institution may charge a fee for electronic transfers.

Important: For a checking account, a pre-printed VOIDED check is required or documentation with complete account information (routing number, account number, accountholder's name) on your bank's letterhead. For a savings account, a pre-printed deposit slip with information necessary to complete electronic funds transfers (routing number, account number, accountholder's name and account registration) is required or documentation with complete account information on your bank's letterhead. Please attach a VOIDED check or deposit slip below. Please include other bank account documentation with this page.

Indicate account type: ◯ Checking Account ◯ Savings Account

John Doe
123 Main Street
Anytown, USA 12345

0000

_____ VOID _____ $ ☐

_____ **Please tape your voided check here** _____

Memo: _____ _____

AUTHORIZATION AND DISCLAIMER

I hereby authorize and direct State Farm Life Insurance Company/State Farm Life and Accident Assurance Company ("State Farm") to initiate credit entries (deposits) into my designated financial accounts, and to initiate debit entries (withdrawals) if necessary to reverse erroneous deposits.

This authority will remain in effect until State Farm and the relevant depository institution have had reasonable opportunity to act upon valid, written notification from me directing otherwise. I understand that this service may be discontinued by State Farm at any time.

State Farm is not responsible for any loss or delay resulting from my submission of erroneous or incomplete information.

Signature of Policyowner _____ Date _____

Signature of Agent as Witness (Not Required) _____ Date _____

Agent's Code Stamp