Going Beyond TOLIC
Trans-Oceanic Life Insurance Company Of America

Dependent Inclusion Request Form

Please write legibly. All fields are required.

Policy Holder Information

Policy Holder Name	SSN
Payer Name	Payer SSN
Postal Address	ZIP Code
Phone Number	E-Mail

Dependent's Information

Name	Date of Birth	Relationship	SSN	Occupation
	MM / DD / YYYY			
Name	Date of Birth	Relationship	SSN	Occupation
	MM / DD / YYYY			
Name	Date of Birth	Relationship	SSN	Occupation
	MM / DD / YYYY			

Have you, any of the dependents or additional insured been treated, diagnosed or had knowledge about problems or conditions of Cancer, Diabetes, Stroke, Heart Attack or any heart condition in the last five (5) years?	☐ Yes ☐ No
Have you, any of the dependents or additional insured been treated or diagnosed by a licensed Cancer or Skin Cancer doctor during the last ten (10) years?	☐ Yes ☐ No
If you have answered in the affirmative to any of the questions indicated above, the requested coverage will be subject to approval in accordance with the Company's eligibility requirements.	

I hereby state that all the answers and statements contained herein are complete in details and are true.	Signed in
	Date MM / DD / YYYY

IMPORTANT NOTICE

Any person who knowingly and with the intention of damaging, committing fraud or deceiving an insurer submits a claim or request that contains false, incomplete or misleading information is guilty of a third degree felony.

Policy Holder's Signature

Payer's Signature

FOR OFFICE USE ONLY

Proccessed by: _____ Date: _____

Email: customerservice@tolic.com
Customer Service: 1-800-981-8662
Postal Address: PO BOX 691628 Orlando FL, 32869 **Physical Address:** 4700 Millenia Blvd Suite 500 Orlando FL, 32839