Going Beyond TOLIC
Trans-Oceanic Life Insurance Company Of America

Payer Change Request

Please write legibly. All fields are required.

Policy Holder Information

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

New Payer Information

New Payer Name	SSN
Date of Birth	Gender ☐ Female ☐ Male
Phone Number	E-Mail
Postal Address	ZIP Code
Relationship with the Current Payer	

☐ **Electronic Transfers:** ☐ Monthly (COM) ☐ Credit Card

Frequency ☐ Monthly ☐ Quarterly ☐ Semi Annual ☐ Annual

Bank information

☐ Checking Account ☐ Savings Account	Account number:	ABA routing number:
Name of Financial Institution:	Branch office:	Transfer day:

☐ VISA ☐ MasterCard ☐ American Express	Card number:	Security Code (CVC):
Expiration date: MM/AAAA	Name on the card:	Transfer day:

8240 Exchange Drive, Suites Cloud 1 and 2, Orlando, Florida 32809
Policy Holder Support: : 1-800-981-8662 - **Email**: customerservice@tolic.com

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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.

New Payer's Signature

Policy Holder's Signature

FOR OFFICE USE ONLY

Proccessed by: _____ **Date:** _____

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