PAMANA
FUNERAL EXPENSE BENEFIT

Change Benefit Plan

PRINT LEGIBLY

2565 Alluvial Ave. Ste. 142
Clovis, CA 93611
1-855-54-PAMANA
1-855-547-2626

Current Plan_____Covered Participant Name_____

Owner (If other than covered participant)_____

Instructions for completing this form:

1. This form must be completed in ink and cannot be altered by the use of correction fluid.
2. Please print legibly.
3. The plan owner must sign the form.
4. List each covered and the new face value you want.
5. If the coverage includes or a Child add-on, indicate the number of children.

I hereby Request that the coverage of the listed benefit be reduced as indicated below. I understand that the contributions will be adjusted accordingly and will be reflected on the corrected coverage schedule.

Covered Participant's Name:_____

Current Plan _____

Child add-on Coverage_____

Covered Participant's Name:_____

New Plan _____

Child add-on Coverage_____

If the contributions were being paid automatically from a bank account or credit/debit card, do you wish to resume that payment method? ___Yes ____No

_____ _____
Signature of Owner Date

_____ _____
E-mail Address Phone Number

NOTE: Once this form is received and filed at the Headquarters, we will send you an endorsement and a corrected copy of the plan.