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## ADDRESS CHANGE REQUEST

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Policy Number \_\_\_\_\_ Date \_\_\_\_\_

Insured \_\_\_\_\_

Owner (If other than Insured) \_\_\_\_\_

**Please change the address of the**  **Insured**  **Owner**  **Payor**

**PREVIOUS ADDRESS:**

\_\_\_\_\_ Street

\_\_\_\_\_ City State Zip Code

**NEW ADDRESS:**

\_\_\_\_\_ Street

\_\_\_\_\_ City State Zip Code

( ) ( )  
Home Phone Number Work Phone Number

If owner is an individual or partnership, please sign in the following section:

\_\_\_\_\_  
Signature of Owner

If owner is a corporation, please sign in the following section:

\_\_\_\_\_  
Signature of Corporate Officer Title / Signature of Corporate Officer Title

**Please submit the completed form to Symetra Life Insurance Company  
by fax: 1-866-532-1361, or mail: PO Box 7902 London, KY 40742-7902**