

Change of Death Benefit

For policy no.	
	1 st Policyholder <input type="checkbox"/> legal entity
Name/First name/Company	
Address/ZIP code/Country	
Date of birth/Incorporation date	
Telephone number	
E-mail <input type="checkbox"/> none	
Legal representative	
	2 nd Policyholder <input type="checkbox"/> legal entity
Name/First name/Company	
Address/ZIP code/Country	
Date of birth/Incorporation date	
Telephone number	
E-mail <input type="checkbox"/> none	
Legal representative	
Insured person	
	1 st insured person
Name/First name/Company	
Address/ZIP code/Country	
Date of birth/Incorporation date	
Telephone number	
E-mail <input type="checkbox"/> none	
Gender	<input type="checkbox"/> male <input type="checkbox"/> female
	2 nd insured person
Name/First name/Company	
Address/ZIP code/Country	
Date of birth/Incorporation date	
Telephone number	
E-mail <input type="checkbox"/> none	

Gender	<input type="checkbox"/> male	<input type="checkbox"/> female
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Death benefit

Present death benefit	_____ %
NEW death benefit	_____ %

Health questions and Information on insured persons

	1. insured person		2. insured person	
Are you healthy and fit for work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No*	<input type="checkbox"/> Yes	<input type="checkbox"/> No*
Have you suffered from any illness, impairment, disability or any chronic conditions in the last 5 years?	<input type="checkbox"/> Yes**	<input type="checkbox"/> No	<input type="checkbox"/> Yes**	<input type="checkbox"/> No
Height / weight	_____ cm	_____ kg	_____ cm	_____ kg

*) Please explain

***) Name and address of the doctor or the hospital where you were treated (see explanation below)

The policyholder is required to notify Youplus immediately in writing of any changes in the health of the insured person up to the commencement of the insurance. The insured person further agrees that doctors, hospitals, insurance carriers, authorities, etc. may provide information to Youplus and release them from their obligation to maintain confidentiality by issuing this mandate. Depending on your age, health status and selected risk protection, additional health questions or further medical examinations may be required. Youplus will, if necessary, approach the policyholder or the insured person.

Signature of the policyholder (handwritten signature required)

Place, Date	1 st and 2 nd policyholder/Legal representative*
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Signature of the insured person (handwritten signature required)

Place, Date	1 st and 2 nd insured person*/Legal representative*
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Compulsory enclosures - Youplus reserves the right to request any additional document if needed:

- Original policy** (incl. any appendix) or declaration of loss
- If the policyholder is a natural person, **Utility Bill** as proof of residence, not older than 12 months (or 6 months for Irish policies) (e.g. gas, electricity or water bill, TV license et. al.) or proof of registration
- Identification documents** for each policyholder/insured person (if different):
 - Natural person:** certified copy of the valid passport or identity card (if not already submitted)
 - Company/Legal entity:** trade register (not older than 12 months), statutes (or equivalent document), authorized signatory list, certified copy of the valid passport or identity card for each person authorized to sign and corresponding W-8 or W-9 form
- Form **"Self certification regarding tax status"** for each policyholder/insured person (if different).
- In case of Irish policy: **"Form Self declaration of non-Irish residence"**
- For natural person or legal entity with **US Status:**
 - W-9 form
 - FinCEN Report 114 (FBAR for the most recent tax year concerning the Policy) **and**
 - Form 8938 (for the most recent tax year concerning the Policy)
 - or** CPA-letter (confirmation for the most recent tax year concerning the Policy)

*The same documents and information requested for the policyholder will be needed for the legal representative. Please complete page 1 accordingly.
