SONS OF NORWAY
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Application for Certificate Change

I, _____, Insured/Owner *(if other than insured)* of Certificate Number _____
hereby make application for the following certificate changes to be effective from _____.
Change the Amount from _____ to _____.
Change the Plan from _____ to _____.
Other changes _____
_____
Change the Premium from _____ due _____ to _____ due _____.

➔ Please elect one of the following *(if applicable)*:
- ❑ I elect NOT to have Federal Income Tax Withheld.
- ❑ I elect to have Federal Income Tax Withheld.

➔ ***Under penalties of perjury, I certify that my Taxpayer ID No. (Social Security No.) is:***

Insured : _____-_____-_____

Owner: _____-_____-_____

I hereby agree that these changes shall be an amendment to my original application and shall form a part of my certificate.

Questions to be answered by the Insured

1. Have you been ill since date of the above certificate? If so, state nature of illness, date and duration.

2. Have you consulted a physician since date of above certificate? If so, whom, for what, and when?

3. (a) What is your present occupation? Give details of duties. (b) How long have you been engaged in this occupation?

4. (a) Have you, during the past 24 months, taken an aerial flights other than as a passenger on a commercial airline?

❑ No ❑ Yes *(If Yes, how many? _____)*

(b) Do you contemplate taking flights other than as a passenger on a commercial airline? ❑ No ❑ Yes

I hereby ratify and confirm all the statements made in the application and amendments thereto upon which the above-numbered certificate was issued except such as are modified by representations or agreements herein contained, and hereby make the original application and this application for change both parts of the contract for insurance.

I further agree that if any statements made or contained herein, the truthfulness of all which I hereby expressly affirm, be untrue in any respect, then this application shall be ipso facto null and void; also that this application shall not be in force until approved by the Company at its Headquarters, and during my lifetime and continuance of good health.

Dated at *(city)*: _____ State: _____ Date: _____ Witnessed by: _____

Signature of Insured: _____

Signature of Owner *(if other than insured)*: _____

Address: _____ City: _____

State: _____ Zip: _____ Email Address: _____