



P O Box 989, Manchester, NH 03105-0989 603.625.8577 800.222.8577 Fax: 603.625.1214 www.aca-assurance.org
ACA is a Fraternal Life & Health Insurance Benefit Society Established in 1896 as Association Canado-Américaine

Date: _____

To: _____

You recently contacted our office with a request to surrender your life insurance policy.

Please complete the enclosed “Request for Cash Surrender Value or Non-Forfeiture Values” form. We also request that you send us the actual policy. In the event that you have misplaced the policy, please complete and return the “Declaration of Lost Policy” form that is enclosed for your convenience.

All documents should be mailed to: ACA Assurance in Rehabilitation, P O Box 989, Manchester, NH 03105-0989. Providing all documents are completed correctly, your request will be processed within 30 days.

Fraternally,
ACA ASSURANCE IN REHABILITATION



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REQUEST FOR CASH SURRENDER VALUE OR NON-FORFEITURE VALUES

Policy Number: _____

Insured's Name: _____

Policy Owner's Name: _____ Social Security N^o: _____

Street: _____

City: _____ State: _____ Zip: _____

I understand that all outstanding liens, loans and premiums due on this policy will be deducted from the surrender value of my policy.

I hereby certify under pains and penalties of perjury that I have not assigned or transferred ownership of this policy to any other individual or entity and that I am the legal owner of this policy.

I agree to have no Federal/State (if applicable) income tax withheld from my distribution.

IN WITNESS WHEREOF, I have signed this request under pains and penalties of perjury at:

_____ city state

this _____ day _____ month _____ year

Signature of Policy Owner

Witness

This form must be signed by the owner or, if the owner is not yet 18 years of age, by the sponsoring applicant who signed the original insurance application form.

This form together with the Insurance Policy must be mailed to the Home Office, Post Office Box 989, Manchester New Hampshire 03105-0989

Any person who, with the purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20



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DECLARATION OF LOST POLICY

Re: Policy No. _____

City/ Town _____

I, the undersigned, declare:

That _____
(Name of Member)

Held a policy of insurance the beneficiary being

Relationship _____

That the said insurance policy is lost and not available, nor can it be produced.

Signature of Claimant (or Representative)

Signature of Witness

Address _____

