



# Trinity Life Insurance Company

ADMINISTRATIVE OFFICE  
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## CHANGE MODE OF PREMIUM PAYMENT

**Policy Number:**

POLICY NUMBER 1	POLICY NUMBER 2	POLICY NUMBER 3	POLICY NUMBER 4

**Insured's Full Name:** \_\_\_\_\_

- ANNUAL
- SEMI-ANNUAL
- PREAUTHORIZED TRANSFER PLAN (PAT) - Monthly Only  
*(Attach new PAT card and voided check)*

Date: \_\_\_\_\_

X  
\_\_\_\_\_  
Owner's Name (printed)

X  
\_\_\_\_\_  
Owner's Signature (Always Required)

\_\_\_\_\_  
Owner's email address

( )  
\_\_\_\_\_  
Owner-Day time phone:  Home  Cell  Work

X  
\_\_\_\_\_  
Co-Owner's Name (printed)

X  
\_\_\_\_\_  
Co-Owner's Signature (Required if Co-Owner exists)

\_\_\_\_\_  
Co-Owner's email address

( )  
\_\_\_\_\_  
Co-Owner-Day time phone:  Home  Cell  Work