Physicians Mutual®
Insurance for all of us.®

Physicians Mutual Insurance Company,Inc.
PO Box 3313
Omaha, NE 68103-0313 1.800.228.9100

Service Request

Please check the appropriate box for each change or service you are requesting. Please print the requested information.

Policyowner/Insured Information

Policyowner's Name _____

Insured's Name (If different from policyowner) _____

Policy Number _____ Policy Number _____

Policy Number _____ Policy Number _____

Insured's Date of Birth ____/____/____
Month Day Year

☐ **Name Change** (Attach copy of legal document)
☐ Owner ☐ Insured

From _____ To _____
Last First Middle Last First Middle

Reason ☐ Marriage ☐ Divorce ☐ Other

☐ **Address Change**
☐ Owner ☐ Insured ☐ Third Party Contact

Address _____ _____
Street Apartment Number

_____ _____
City State ZIP County

Phone Number (____) _____ Fax Number (____) _____

Email Address _____
(For service and product updates from us.)

☐ **Date of Birth Correction** (Date of Birth changes require a copy of your Driver's License or Birth Certificate.)
☐ Owner ☐ Insured

My correct Date of Birth is ____/____/____ rather than ____/____/____
Month Day Year Month Day Year

☐ **Replacement Policy Request**
☐ I, the undersigned, am the unconditional policyowner of the policy(ies) listed above. I certify the original policy(ies) has been lost, stolen or destroyed, it has not been pledged or assigned and is not being held in the possession of another person.
☐ Replacement ID Card ☐ Vision Replacement ID Card ☐ Vision and Hearing Replacement ID Card
☐ Replacement Billing Statement ☐ Duplicate Policy

Signature and Acknowledgment

To the best of my knowledge and belief, the statements and answers contained in this request are true and complete. I understand the request will not become effective until approved by the Company in accordance with the terms of the contract.

X _____ _____
Policyowner's Signature Date

X _____ _____
Insured's Signature (If different from Policyowner) Date