

**NAME CHANGED BY
COURT ORDER**



Return completed form to:
State of Wisconsin
Office of the Commissioner of Insurance
State Life Insurance Fund
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-0107 • 1-800-562-5558

Ref: Section 604.04 (7), Wis. Stat.

INSTRUCTIONS:

In order to change your name in our records, please:

- Attach a copy of the Order by the Court changing your name;
 - Complete information below and sign the form.
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Policy Owner Name
Address
City, State Zip
Phone Number

Insured Name	Date of Birth	Policy Number	Last Four Digits of SSN XXX - XX - _____
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I hereby declare that my name was changed by Court Order on _____
(Month, Day, Year)
at _____ from _____
(City and State) (Previous Name)
to _____ and request that my name be changed in the
(Current Legal Name)

ATTACH COPY OF THE ORDER BY THE COURT.

(Signature of Insured)

(Date)