Employee Request for Changes

Products and financial services provided by
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This form should be completed for all Employee request for changes that require an Employee's signature and date. These types of requests include:

- **Change of Address**
- **Name Change** (Due to Marriage or Divorce)
- **Request to Reinstate Coverage**
  - If Employee returns to work within the reinstatement period AND was enrolled in Employee paid coverage prior to leaving employment.
- **Life Event Benefit under Voluntary Term Life contract**
  - Should be completed when an Employee has recently married or had a child and wishes to increase Voluntary Term Life volume.
  - This option is only allowed if elected by the Policyholder and the Employee meets all criteria indicated in the contract.
- **Life Event Benefit under Lump Sum Disability contract**
  - Should be completed when an Employee has recently married or had a child and wishes to add Lump Sum Disability or increase current Lump Sum Disability volume.
  - This option is only allowed if elected by the Policyholder and the Employee meets all criteria indicated in the contract.
- **Family Status Change under Worksite Disability contract**
  - Should be completed when an Employee has recently married or had a child and wishes to add Worksite Disability or increase current Worksite Disability coverage.
  - This option is only allowed if elected by the Policyholder and the Employee meets all criteria indicated in the contract.
- **Request to Add Dependent Coverage**
  - Should be completed when an Employee has recently married and wishes to add the newly eligible Spouse.
  - Should be completed when an Employee has recently acquired a child (birth or adoption) Dependent eligibility must be determined using the contract.
- **Request to Terminate Employee Coverage**
  - This section should be completed when an Employee is still actively at work but wishes to no longer pay for Employee paid coverages. Employees cannot withdraw from Employer paid coverages without submitting a written letter explaining the reason(s) they do not wish to be covered.
- **Request to Reduce Employee Coverage**
  - This section should be completed when an Employee is requesting to reduce their Employee paid coverage.

The signature page must be signed and dated by the Employee. Signatures by someone other than the Employee will be considered null and void.

G-24000 4/12/19

Policyholder and Employee Information *(This section must always be completed)*

Policyholder's Name: _____ Policyholder's No.: _____

Insured's Name: _____ Insured's Social Security No.: _____

Date of Birth: _____ Email Address: _____

Section A – Change of Address

Old Address: _____
Street Address *City* *State* *Zip Code*

New Address: _____
Street Address *City* *State* *Zip Code*

Section B – Name Change

I hereby request my name to be changed from: _____
First *Middle Initial* *Last*

To: _____ Reason for Change: _____
First *Middle Initial* *Last*

Section C – Request to Reinstate Coverage

☐ I hereby wish to reinstate all coverages including all Employee paid coverage I was enrolled in prior to the date of my termination. I understand that all coverages will be reinstated as they were prior to my termination and any increase in coverage will require evidence of insurability.

Employed Full-Time	*Authorized to Work and Reside in the U.S.?*	*Gender*	*Hours Worked*
☐ Yes ☐ No	☐ Yes ☐ No	☐ Male ☐ Female	

Section D – Life Event Benefit under Voluntary Term Life Contract

☐ I am requesting the additional amount of coverage offered and available without evidence of insurability as a result of a life event, such as marriage or a child's birth, adoption, guardianship, or coverage required pursuant to state law or court order.

Full Name	*Relationship to Insured*	*Date of Birth*	*Date Acquired*	*Full-Time Student (if 19 or older)*
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Section E – Life Event Benefit under Lump Sum Disability Contract

☐ I am requesting to add Lump Sum Disability coverage or an additional amount of coverage offered and available without evidence of insurability as a result of a life event, such as marriage or a child's birth, adoption, guardianship, or coverage required pursuant to state law or court order. I will receive the Life Event Benefit amount listed on the Schedule of Benefits for any dependents listed below.

Full Name	*Relationship to Insured*	*Date of Birth*	*Date Acquired*	*Full-Time Student (if 19 or older)*
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Section F – Family Status Change under Worksite Disability Contract

☐ I am requesting to add Worksite Disability coverage or an additional amount of coverage offered and available without evidence of insurability as a result of a family status change, such as marriage or a child's birth, adoption, guardianship, or coverage required pursuant to state law or court order. I will receive the Family Status Change as outlined in the contract for any dependents listed below.

Full Name	*Relationship to Insured*	*Date of Birth*	*Date Acquired*	*Full-Time Student (if 19 or older)*
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

To add dependent coverage due to a life event, complete the next section

Section G – Request to Add Dependent Coverage

I hereby request the addition of the coverages selected below for the following dependents:

☐ Term Life/AD&D ☐ Supplemental Life/AD&D ☐ Voluntary Term Life/AD&D

Full Name		*Relationship to Insured*	*Date of Birth*	*Gender*	*Date Acquired*	*Full-Time Student (if 19 or older)*
				☐ Male ☐ Female		☐ Yes ☐ No Anticipated Graduation Date _____
Volume/Option	***Social Security Number***	***Reason***				
		☐ Marriage ☐ Birth ☐ Adoption ☐ Court Order *(attach a copy)* ☐ Other_____				
Full Name		*Relationship to Insured*	*Date of Birth*	*Gender*	*Date Acquired*	*Full-Time Student (if 19 or older)*
				☐ Male ☐ Female		☐ Yes ☐ No Anticipated Graduation Date _____
Volume/Option	***Social Security Number***	***Reason***				
		☐ Marriage ☐ Birth ☐ Adoption ☐ Court Order *(attach a copy)* ☐ Other_____				
Full Name		*Relationship to Insured*	*Date of Birth*	*Gender*	*Date Acquired*	*Full-Time Student (if 19 or older)*
				☐ Male ☐ Female		☐ Yes ☐ No Anticipated Graduation Date _____
Volume/Option	***Social Security Number***	***Reason***				
		☐ Marriage ☐ Birth ☐ Adoption ☐ Court Order *(attach a copy)* ☐ Other_____				

Section H – Request to Terminate Employee Paid Coverage

I hereby request the termination of the coverages listed below. I understand that any request to terminate Employee coverage automatically terminates any dependent coverage under that contract. I also understand that the actual termination date of coverage will be based on contract details.

				Requested Termination Date
☐ Term Life/AD&D	☐ Employee	☐ Spouse	☐ Child	_____
☐ Supplemental Life/AD&D	☐ Employee	☐ Spouse	☐ Child	_____
☐ Voluntary Term Life/AD&D	☐ Employee	☐ Spouse	☐ Child	_____
☐ Short Term Disability				_____
☐ Legacy	☐ Employee	☐ Spouse	☐ Child	_____
☐ Long Term Disability				_____
☐ Voluntary Disability	☐ Short	☐ Medium	☐ Long	_____
☐ Lump Sum Disability				_____
☐ Worksite Disability	☐ Short		☐ Long	_____

Reason for withdrawing from Employee Paid coverage:

☐ Divorce ☐ Age Maximum ☐ Spouse's Group Coverage ☐ No Longer a Dependent
☐ Medicare ☐ Other

Section I – Request to Reduce Employee Paid Coverage

I hereby request to reduce my employee paid coverage. I also understand that the actual effective date will be based on contract details.

				Requested Effective Date
☐ Term Life/AD&D	☐ Employee	☐ Spouse	☐ Child	_____
☐ Supplemental Life/AD&D	☐ Employee	☐ Spouse	☐ Child	_____
☐ Voluntary Term Life/AD&D	☐ Employee	☐ Spouse	☐ Child	_____
☐ Short Term Disability				_____
☐ Legacy	☐ Employee	☐ Spouse	☐ Child	_____
☐ Long Term Disability				_____
☐ Voluntary Disability	☐ Short	☐ Medium	☐ Long	_____
☐ Lump Sum Disability				_____
☐ Worksite Disability	☐ Short		☐ Long	_____

Current Amount/Option _____ Reduced Amount/Option _____

Signature of Employee: _____ Date: _____

In Michigan: Signature(s) of Dependent Spouse and Child(ren) over age 18: _____

_____

_____ Date: _____

Fraud Warnings *(For use in AL, AR, DC, LA, NM, TX and WV)*

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Alaska

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona

For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment or fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

Delaware, Idaho, Indiana, Oklahoma

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any statement of claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Florida

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of a claim or an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Washington

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland, Rhode Island

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire, Ohio

Any person who, with a 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.

New Jersey

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Oregon

Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or any other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.

Virginia

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.