CLEAR FORM

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

NYL GBS Customer Service Center
Administered by Infosys McCamish Systems, LLC
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Voluntary Term Life Insurance Change Form

Cornell University - Active Employees Policy Number FLY980026

- The applicant must sign and date this form.
- This form cannot be considered unless received within 30 days of the date it is dated.
- This form can only be used for employee-paid coverages.
- **Important:** Please enter all dates in mm/dd/yyyy format.
- This form cannot be used for address changes. Submit address changes to Cornell University.

Please print (preferably in black ink).

Employee Section

Check one: ☐ Mr. ☐ Mrs. ☐ Ms. Name: *(First)* _____ *(Last)* _____

Social Security Number: _____ Birthdate: _____

Address: *(Street)* _____ *(City)* _____

(State) _____ *(Zip)* _____ Work Phone: _____ Home Phone: _____

Employee ID Number: _____ Sex: ☐ M ☐ F

I Wish to Make the Following Changes to My Voluntary Term Life Insurance Coverage

See your life insurance brochure for the coverage election options for your plan. When selecting new coverage amounts, please ensure that your election(s) match the amounts, salary multiples or unit increments described in your brochure.

CHECK THE APPROPRIATE BOXES:

I want to change my coverage due to a Life Status Change. The Life Status Change is: _____

Date of Event: _____ Type of change requested: _____

☐ **Cancel coverage on the following individuals:** ☐ Employee ☐ Spouse ☐ Child(ren)

Child(ren)'s coverage is a rider to the employee or spouse/domestic partner certificate. Child coverage will be cancelled if the employee or spouse/domestic partner certificate to which it is a rider is cancelled. If dependent coverage is being canceled due to loss of eligibility, conversion may be available. If interested, please contact the above number.

Is this your last dependent child? ☐ Yes ☐ No My dependent child is no longer eligible for coverage as of the following date (mm/dd/yyyy): _____

☐ **Change coverage on the following individuals as indicated below:**

☐ Employee: I would like my insurance amount to match the following *(check one)*:

☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x ☐ 6x ☐ 7x ☐ 8x ☐ 9x ☐ 10x Annual Salary.

☐ Spouse ***Current*** Voluntary Coverage: _____ ***New*** Voluntary Coverage: _____

☐ Child(ren) ***Current*** Voluntary Coverage: _____ ***New*** Voluntary Coverage: _____

☐ **Name Change:**

☐ Employee ***Current*** Name: _____ ***New*** Name: _____

☐ Spouse ***Current*** Name: _____ ***New*** Name: _____

☐ **Beneficiary Designations:**

If you'd like to designate new beneficiaries, please go online or complete a Beneficiary Form.

Acceptance/Declination

I authorize the above changes to my Voluntary Term Life coverage. I understand that certain changes may require medical information which will be requested by the Insurance Company if necessary. I authorize my employer to make the appropriate payroll deductions for changes noted above.

Signature:	Date (mm/dd/yyyy):
X	

CLICK TO PRINT

Be sure to make a copy for your own records