



Voluntary Term Life Insurance Change Form

- 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.

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)

Change coverage on the following individuals as indicated below:

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

Spouse (in units of \$10,000)

- Child(ren) \$2,000 \$4,000 \$6,000 \$8,000 \$10,000 \$12,000 \$14,000 \$16,000 \$18,000 \$20,000

Name Change:

- Employee Current Name: New Name:
Spouse Current Name: New Name:

Reminder: 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