NEW YORK LIFE GROUP BENEFIT SOLUTIONS

Request for Change Form
Personal Accident Insurance (PAI)
Policy #YOK-008416
Cornell University - Active Employees

NYL GBS Customer Service Center
Administered by Infosys McCamish Systems, LLC
PO Box 14577
Des Moines, IA 50306-3577
1.800.231.1193
Facsimile 1.877.435.7181
Collect 470.947.3435 from
Alaska or Outside the U.S.A.

CLEAR FORM

Use this form if you are adjusting existing employee, spouse/domestic partner, or dependent children coverage.

Employee Information

1. ☐ Insured, please check box if this is an address change

Last Name	First Name	Middle Initial
Mailing Address		
City	State / Zip Code	Employer Name
Social Security Number	Date of Birth	Sex ☐ Male ☐ Female / Daytime Telephone Number
Eligible Earnings	Date of Hire	Certificate Number(s)

Spouse/Domestic Partner Information

Last Name	First Name	Middle Initial
Social Security Number	Date of Birth	Sex ☐ Male ☐ Female

Above Section Must Be Fully Completed for All Requests Checked Below

2. ☐ Name Change Of:

☐ Employee ☐ Spouse/Domestic Partner

From: *(Last, First, Middle)*

To: *(Last, First, Middle)*

Reason for Change:

3.

☐ **A.** Change the amount of insurance coverage to: Employee Benefit Amount $ _____

(in $10,000 increments up to $500,000. If you elect a benefit amount over $250,000, the amount cannot exceed 10 times your based annual salary.)

Spouse/Domestic Partner: ☐ 100% of my benefit ☐ 50% of my benefit

Dependent Child(ren): ☐ 10% of my benefit

☐ **B.** Cancel coverage for:

☐ Employee ☐ Spouse/Domestic Partner ☐ Child(ren)

If employee coverage is cancelled, spouse/domestic partner and/or child coverage will automatically be cancelled.

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):

If dependent coverage is being canceled due to loss of eligibility, conversion may be available. If interested, please contact the above number.

I authorize the above changes to my Personal Accident Insurance (PAI) Coverage. I understand that any increases or additions to my coverage or my dependent's coverage are subject to approval by the Insurance Company. I authorize my employer to make the appropriate payroll deductions for changes noted above.

Employee's Signature:	Date: *(Month, Day, Year)*

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