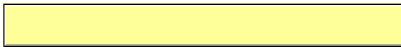


Request for Service Life Change Form
Group Universal Life Insurance (GUL) - Policy #02-L104410
Cornell University

Cigna Customer Service Center
 Administered by Infosys McCamish Systems, LLC



Last Name		First Name		Middle Initial	Certificate No.
Mailing Address					Residence Telephone #
City	State	Zip Code	Employer Name		
Social Security #	Date of Birth	Sex	<input type="radio"/> Male	<input type="radio"/> Female	Daytime Telephone #

ABOVE SECTIONS MUST BE FULLY COMPLETED

A. Name change of: Insured Owner / Certificate Holder Other _____

From: (First, Middle, Last) _____

To: (First, Middle, Last) _____

Reason for Change: _____

* B. Change the amount of insurance coverage to \$ _____

* C. Add / Cancel coverage for my dependent children in the amount of \$ _____ Add Cancel

If cancel - is this your last dependent child? Yes No * Medical Information may be required

Name	Birthdate	<input type="radio"/> Add	<input type="radio"/> Cancel
Name	Birthdate	<input type="radio"/> Add	<input type="radio"/> Cancel

D. My dependent child is no longer eligible for coverage as of the following date (Mo., Day, Yr.): _____
 Please send rates and enrollment information for a separate certificate for that child.

E. Change the monthly contribution to my Cash Accumulation Fund.

Employee Increase Decrease New Amount \$ _____

Spouse Increase Decrease New Amount \$ _____

F. Add a lump sum contribution to my Cash Accumulation Fund (Check enclosed) Amount: \$ _____
 (Please note all lump sum contributions are subject to a state premium tax and IRS Guidelines)

* G. Add/Cancel the Accelerated Payment Benefit ** Add Cancel * Medical Information may be required

* H. Add/Cancel the Automatic Increase Option ** Add Cancel **Please refer to Coverage Option Page of enrollment booklet if an applicable benefit.

I. Change my address to: _____

J. I am terminating my employment and wish to be billed at my home.

K. I wish to: _____

* L. I want to change my coverage due to a Life Status Change. The Life Status Change is: _____
 Date of event: _____ Type of change requested: _____

I authorize the above changes to my Group Universal 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. (Does not apply to those being billed at their home).

Owner's Signature: _____ Date (Mo., Day, Yr.): _____

Group Universal Life Insurance policies are underwritten by Connecticut General Life Insurance Company and Life Insurance Company of North America, Cigna companies.

