Request for Change Form
Insperity Holdings, Inc.

CLEAR FORM

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 515.243.1776 from
Alaska or Outside the U.S.A.

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

Last Name	First Name	Middle Initial

Mailing Address	Residence Telephone #

City	State	Zip Code	Employer Name
			INSPERITY HOLDINGS, INC.

Social Security No.	Date of Birth	Sex	Daytime Telephone #
		☐ Male ☐ Female	

ABOVE SECTION MUST BE FULLY COMPLETED

☐ **NAME CHANGE OF:**

☐ Employee ☐ Spouse/ Domestic Partner ☐ Owner / Certificate Holder

From: *(Last, First, Middle)*

To: *(Last, First, Middle)*

Reason for Change:
☐ Marriage ☐ Divorce
☐ Other _____

VOLUNTARY TERM LIFE INSURANCE Policy No. FLI980027

☐ * A. Change the amount of insurance for: ☐ Employee to: $ _____ ☐ Spouse/ Domestic Partner to: $ _____

☐ * B. Add coverage for my spouse/ domestic partner. An application will be sent to you to complete this request. Refer to the Rates and Plan Sheet of the enrollment brochure for available coverage options.

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

If cancel, is this your last dependent child? ☐ Yes ☐ No

Child's Name	Birthdate	☐ Add ☐ Cancel
Child's Name	Birthdate	☐ Add ☐ Cancel

☐ D. My dependent child is no longer eligible for coverage as of the following date *(mm/dd/yyyy)*: _____
Please send rates and enrollment information for a separate certificate for that child.

☐ E. Change My Address To: _____
Applies only to those being billed at their home. If having payroll deductions, any address changes must be done through Insperity.

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

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

☐ H. I wish to: _____

Medical information may be required

CONTINUED ON BACK. PLEASE SIGN AND DATE THE BACK OF THE FORM.

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE Policy No. OK823223

☐ A. Change Coverage option to: ☐ Employee Only ☐ Employee and Family

☐ B. Change the multiple of coverage to: ☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x ☐ 6x Covered Earnings

☐ C. I wish to: _____

VOLUNTARY DISABILITY INSURANCE Policy No. SLK030024

Eligibility for Voluntary Disability Insurance is determined by the Insperity benefits package available to you and may be affected by your participation in other benefit programs. Please confirm that Voluntary Disability Insurance is available to you by calling Insperity, toll-free, at 1-866-715-3552 weekdays between 7 a.m. and 7 p.m. CT.

AUTHORIZATION AND SIGNATURE

I authorize the above changes to my coverage(s). 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.)*

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