

# Request for Change Form Accidental Death & Dismemberment (AD&D) Insurance

NYL GBS Customer Service Center  
Administered by Infosys McCamish Systems, LLC



GROUP BENEFIT  
SOLUTIONS

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

EMPLOYEE INFORMATION				
<b>1.</b> <input type="checkbox"/> Insured, please check box if this is an address change	LAST NAME	FIRST NAME	M.I.	CERTIFICATE #(s)
	MAILING ADDRESS			
	CITY	STATE	ZIP CODE	EMPLOYER NAME
	SOCIAL SECURITY #	DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DAYTIME TELEPHONE #
	ELIGIBLE EARNINGS	DATE OF HIRE		
SPOUSE/DOMESTIC PARTNER INFORMATION				
	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY #
	BIRTH DATE	SEX <input type="checkbox"/> M <input type="checkbox"/> F		
ABOVE SECTION MUST BE FULLY COMPLETED FOR ALL REQUESTS CHECKED BELOW				
<b>2.</b> <input type="checkbox"/> Name Change of:	<input type="checkbox"/> Employee <input type="checkbox"/> Spouse/Domestic Partner		REASON FOR CHANGE:	
	FROM (First, Middle, Last)			
	TO (First, Middle, Last)			
<b>3.</b> <input type="checkbox"/> <b>A.</b> Change the amount of insurance coverage to:	Employee Benefit Amount _____			
	Spouse/Domestic Partner: <input type="checkbox"/> 100% of my benefit <input type="checkbox"/> 50% of my benefit Dependent Child(ren): <input type="checkbox"/> 10% of my benefit			
<input type="checkbox"/> <b>B.</b> Cancel coverage for:	<input type="checkbox"/> Employee <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Child(ren)			
	<i>If employee coverage is cancelled, spouse/domestic partner and/or child coverage will automatically be cancelled.</i>			

I authorize the above changes to my Accidental Death & Dismemberment (AD&D) Insurance 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: \_\_\_\_\_

Spouse's/Domestic Partner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**Make a copy of this form for your own records. Return this form in the enclosed postage-paid envelope.**