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Employee Request for Changes Form 24000

Policyholder and Employee Information *(This section must always be completed)*

Policyholder's Name: _____ Policyholder's No.: _____

Insured's Name: _____ Insured's Social Security No.: _____

Date of Birth: _____ Email Address: _____

Section A – Change of Address

Old Address: _____ (Street Address) _____ (City) _____ (State) _____ (Zip Code)

New Address: _____ (Street Address) _____ (City) _____ (State) _____ (Zip Code)

Section B – Name Change

I hereby request my name to be changed from: _____ (First) _____ (Middle Initial) _____ (Last)

To: _____ (First) _____ (Middle Initial) _____ (Last) Reason for Change: _____

Section C – Request to Reinstate Coverage

☐ I hereby wish to reinstate all coverages including all Employee paid coverage I was enrolled in prior to the date of my termination. I understand that all coverages will be reinstated as they were prior to my termination and any increase in coverage will require evidence of insurability.

Employed Full-Time	Authorized to Work and Reside in the U.S.?	Gender	Hours Worked
☐ Yes ☐ No	☐ Yes ☐ No	☐ Male ☐ Female	

Section D – Life Event Benefit under Voluntary Term Life Contract

☐ I am requesting the additional amount of coverage offered and available without evidence of insurability as a result of a life event, such as marriage or a child's birth, adoption, guardianship, or coverage required pursuant to state law or court order.

Full Name	Relationship to Insured	Date of Birth	Date Acquired	Full-Time Student (if 19 or older)
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Section E – Life Event Benefit under Lump Sum Disability Contract

☐ I am requesting to add Lump Sum Disability coverage or an additional amount of coverage offered and available without evidence of insurability as a result of a life event, such as marriage or a child's birth, adoption, guardianship, or coverage required pursuant to state law or court order. I will receive the Life Event Benefit amount listed on the Schedule of Benefits for any dependents listed below.

Full Name	Relationship to Insured	Date of Birth	Date Acquired	Full-Time Student (if 19 or older)
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Section F – Family Status Change under Worksite Disability Contract

☐ I am requesting to add Worksite Disability coverage or an additional amount of coverage offered and available without evidence of insurability as a result of a family status change, such as marriage or a child's birth, adoption, guardianship, or coverage required pursuant to state law or court order. I will receive the Family Status Change as outlined in the contract for any dependents listed below.

Full Name	Relationship to Insured	Date of Birth	Date Acquired	Full-Time Student (if 19 or older)
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

To accurately complete Employee Request for Changes Form:

IMPORTANT: *This form is to be completed by the employee when requesting changes to Voluntary coverage. Ensure that the Policyholder and Employee Information have been completed.*

Section B

Please make sure employees are completing this section when they have a name change.

Section C

Employees should only complete this section if they are rehired within the reinstatement guidelines of the group contract for Voluntary coverage.

Section D, E, & F (Page 2 & 3)

This page is to be completed when an employee has a life event. In this section they will need to ensure the "volume/option" amount or number is indicated, when applicable.

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To add dependent coverage due to a life event, complete the next section

Section G – Request to Add Dependent Coverage

I hereby request the addition of the coverages selected below for the following dependents:

☐ Term Life/AD&D ☐ Supplemental Life/AD&D ☐ Voluntary Term Life/AD&D

Full Name	Relationship to Insured	Date of Birth	Gender	Date Acquired	Full-Time Student (if 19 or older)
			☐ Male ☐ Female		☐ Yes ☐ No Anticipated Graduation Date

Volume/Option	Social Security Number	Reason
		☐ Marriage ☐ Birth ☐ Adoption ☐ Court Order *(attach a copy)* ☐ Other

Full Name	Relationship to Insured	Date of Birth	Gender	Date Acquired	Full-Time Student (if 19 or older)
			☐ Male ☐ Female		☐ Yes ☐ No Anticipated Graduation Date

Volume/Option	Social Security Number	Reason
		☐ Marriage ☐ Birth ☐ Adoption ☐ Court Order *(attach a copy)* ☐ Other

Section G

To be completed by employees when adding dependent coverage due to a life event.

Section H – Request to Terminate Employee Paid Coverage

I hereby request the termination of the coverages listed below. I understand that any request to terminate Employee coverage automatically terminates any dependent coverage under that contract. I also understand that the actual termination date of coverage will be based on contract details.

				Requested Termination Date
☐ Term Life/AD&D	☐ Employee	☐ Spouse	☐ Child	
☐ Supplemental Life/AD&D	☐ Employee	☐ Spouse	☐ Child	
☐ Voluntary Term Life/AD&D	☐ Employee	☐ Spouse	☐ Child	
☐ Short Term Disability				
☐ Legacy	☐ Employee	☐ Spouse	☐ Child	
☐ Long Term Disability				
☐ Voluntary Disability	☐ Short	☐ Medium	☐ Long	
☐ Lump Sum Disability				
☐ Worksite Disability	☐ Short		☐ Long	

Reason for withdrawing from Employee Paid coverage:

☐ Divorce ☐ Age Maximum ☐ Spouse's Group Coverage ☐ No Longer a Dependent ☐ Medicare ☐ Other

Signature of Employee: _____ Date: _____

In Michigan: Signature(s) of Dependent Spouse and Child(ren) over age 18: _____

_____ Date: _____

Section H

Must be completed by employees when they are choosing to terminate voluntary coverage. Ensure that this page is included with page 1.

IMPORTANT:

Employee signatures are always required when making changes to Voluntary coverage.