



Please fax to (877) 573-6177
 Total Pages Faxed _____

GROUP INSURANCE CHANGE REQUEST

Employer: Stetson University, Inc. Billing Division: 1288805 DeLand; 1332386 College of Law

Policy Number (List all affected policy numbers): 000010151112, 000010151113, 000400151114

Group ID: STETSONU Insured's Name: _____ Social Security Number: _____

NAME/ADDRESS CHANGE (First, MI, Last):
From:
To:

BENEFICIARY CHANGE	
Primary Beneficiary:	Relationship:
Contingent Beneficiary:	Relationship:
NOTE: Contingent Beneficiary will receive benefits only if Primary Beneficiary does not survive you. If more than one Primary or Contingent Beneficiary is wanted, please attach a separate sheet of paper.	

DEPENDENTS TO BE ADDED OR REMOVED						
Check One		Name (First, MI, Last)	Date of Birth (Mo/Day/Yr)	Relationship (Spouse or Child)	Date of Marriage (Mo/Day/Yr)	Late Entrant (Yes or No)
Add	Remove					

If adding dependent outside eligibility period, please explain reason:
 For foster or adopted child, show date of placement and any adoption decree.
NOTE: If dependents are late entrants for Life coverage, each dependent will need to complete an Evidence of Insurability form and submit it to The Lincoln National Life Insurance Company for review. If dependents are late entrants for Dental coverage, and were previously covered under another plan, please complete the back of this form.

CHANGES IN COVERAGE (For Changes to Accident Coverage see page 2.)
Effective Date of Change: <u>01/01/2018</u> Current Salary: \$ _____
<input type="checkbox"/> 1. Increase Employee Coverage to \$ _____ <input type="checkbox"/> 2. Add/Increase Spouse Coverage to \$ _____ <input type="checkbox"/> 3. Add/Increase Child Coverage to \$ _____
Indicate which coverage the above change is for (ex. Vol life, Optional life, Critical Illness, etc.): _____
Enrollment form must be attached for items 1 - 3. Evidence of Insurability may be required.

Effective Date of Change: <u>01/01/2018</u>
<input type="checkbox"/> 1. Reduce Employee Coverage to \$ _____ <input type="checkbox"/> 2. Reduce Spouse Coverage to \$ _____
Indicate which coverage the above change is for (ex. Vol life, Optional life, Critical Illness, etc.): _____

Date:	Insured's Signature:	Witness' Signature:
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