Lincoln Financial Group℠

The Lincoln National Life Insurance Company, PO Box 2616, Omaha, NE 68103-2616
toll free (800) 423-2765
www.LincolnFinancial.com

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

GROUP INSURANCE CHANGE REQUEST

Employer: Stetson University, Inc Billing Divsion DeLand: 1589029 / COL 1589031

Policy Number (List all affected policy numbers): _____

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 or 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:_____ **Current Salary: $**_____

☐ 1. Increase Employee Coverage to $ _____

☐ 2. Add/Increase Spouse Coverage to $ _____

☐ 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:_____

☐ 1. Reduce Employee Coverage to $ _____

☐ 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: