

**Group Administration Card**

EMPLOYEE'S NAME (PLEASE PRINT) \_\_\_\_\_

EMPLOYER \_\_\_\_\_ POLICY NUMBER \_\_\_\_\_

**A. WAIVER/TERMINATION OF GROUP INSURANCE COVERAGE:** I certify that I have been given an opportunity to apply for the Group Insurance benefits checked below, I understand fully the benefits of the plan, and decline/request termination of the coverage. I understand that any current insurance will terminate at the end of the period of the last premium payment.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> <b>Basic Group Life</b> | <input type="checkbox"/> <b>Additional/Voluntary Group Life</b> | <input type="checkbox"/> <b>Group Short Term Disability</b> |
| <input type="checkbox"/> Myself Only             | <input type="checkbox"/> Myself Only                            | <input type="checkbox"/> <b>Group Long Term Disability</b>  |
| <input type="checkbox"/> My Dependents Only      | <input type="checkbox"/> My Spouse Only                         | <input type="checkbox"/> <b>Group Vision</b>                |
| <input type="checkbox"/> Myself & My Dependents  | <input type="checkbox"/> My Children Only                       | <input type="checkbox"/> My Dependents Only                 |
|  | <input type="checkbox"/> Myself, Spouse & Dependents            |   |

**B. REQUEST FOR REDUCTION IN GROUP INSURANCE COVERAGE:** I request that my benefit be reduced as listed below. I understand that the reduced benefit will be effective on the first day of the month following the date this request form is signed.

Benefit	From	To
<input type="checkbox"/> <b>Additional/Voluntary Group Life</b>		
<input type="checkbox"/> Myself	\$ _____	\$ _____
<input type="checkbox"/> My Spouse	\$ _____	\$ _____
<input type="checkbox"/> My Children	\$ _____	\$ _____
<input type="checkbox"/> <b>Short Term Disability</b>	\$ _____	\$ _____

**Sign here for item A & B:** I understand that if I wish to apply for this insurance at a later date, satisfactory Evidence of Insurability will be required at my own expense.

\_\_\_\_\_ Date \_\_\_\_\_ Signature of Employee

**C. REQUEST FOR CHANGE OF BENEFICIARY:** I hereby designate the person or persons named below as beneficiary, revoking any other beneficiary designation, such change to be effective according to the terms and conditions of the group policy. Unless otherwise provided herein, beneficiaries designated to share proceeds shall share equally and the share of a beneficiary who does not survive me shall be paid to the surviving beneficiary. If no beneficiary survives me, payment shall be made according to the terms of the Policy, subject to revocation by me by written notice to my employer.

<b>PRIMARY BENEFICIARY'S</b> LAST NAME	FIRST NAME	MIDDLE INITIAL	RELATIONSHIP TO YOU
FULL ADDRESS OF BENEFICIARY			PHONE
<b>CONTINGENT BENEFICIARY'S</b> LAST NAME	FIRST NAME	MIDDLE INITIAL	RELATIONSHIP TO YOU
FULL ADDRESS OF BENEFICIARY			PHONE

**D. REPORT OF CHANGE OF NAME:** I hereby request that the records kept in connection with the Group Policy reflect the following change of name:  Insured Person  Beneficiary

\_\_\_\_\_ Date of Change \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

**E. REQUEST FOR ADDITION OF DEPENDENTS:** I hereby apply for Dependent Life insurance on all of my dependents who are now eligible as defined in the Group Policy and any dependents who may hereafter become eligible, subject to revocation by me by written notice to my employer. I authorize the required deduction (if any) from my wages.

\_\_\_\_\_ Date of Marriage \_\_\_\_\_ Spouse's Name \_\_\_\_\_ Number of Eligible Children \_\_\_\_\_

<b>Sign here for item C, D, &amp; E:</b>		<b>Recorded on behalf of the Company subject to the terms and conditions of the Group Policy.</b>	
_____ Date _____	_____ Signature of Employee _____	_____ Date _____	_____ By _____
_____ Date _____	_____ Witness _____		