unum®

REQUEST FOR CHANGE
Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

Instructions

Section 1

Must be completed for all types of changes requested ▶

1

Employer (Firm Name and Street Address)	City	State	Zip Code

(City, State, Zip)	Plan Number	Division Number

Employee Name (Last, First, Middle Initial)	Social Security Number

Employee Address

Section 2

Beneficiary Change Request ▶

- Beneficiary(ies) Name(s) should be given: eg. Smith, Mary J./**not** Smith, Mrs. John J.
- A witness signature must be obtained.

*Please give name of Plan if beneficiaries are Trustees of Pension Plan.

All Beneficiary Change Requests are to be maintained for your files.

2 Change my beneficiary(ies) as of: _____

To: Name (Last, First, Middle Initial)	%*	Relationship
If beneficiary(ies) above not living, then pay		

*Surviving beneficiaries will be paid equally unless otherwise indicated. The change will be effective in accordance with the Group Plan. This beneficiary change cancels and supercedes previous designations and may be changed upon written request.

Witness Signature _____ Date _____

Section 3

Tobacco/No-Tobacco Rate Change Request ▶

3 Check one:

☐ I have not used tobacco products in the last 12 months.
☐ I have begun using tobacco products.

Section 4

Dependent Coverage Request ▶

- Employee must complete this section **only** if this coverage is available.

4 ☐ I request that coverage be **added** under the Group Plan for:

☐ **Spouse**/Marriage date: _____
Attach completed Lifestyle Application or Enrollment Form.

☐ **Child**/Birthdate: _____ Life Amount $_____ AD&D Amount $_____
If requesting dependent coverage, more than 31 days after the date of eligibility, an Evidence of Insurability form must be submitted with the Lifestyle Life enrollment form.

Section 5

Decrease Amount or Discontinue Coverage Request ▶

Note: Discontinuance of coverage for the primary insured will result in the discontinuance of coverage for all dependents (spouse/child).

5 **Decrease** the amount or **Discontinue** coverage for:

Reason _____

Date of Decrease or Discontinuance

Date _____

Insured	Decrease Amount To: Life	Decrease Amount To: AD&D	Discontinue Coverage For: Life	Discontinue Coverage For: AD&D	Discontinue Coverage For: LTD
☐ Self	$	$	☐	☐	☐
☐ Spouse	$	$	☐	☐	☐
☐ Children	$	$	☐	☐	☐

Section 6

Name Change Request

6 Name Change as of: From: To:

Employee Signature _____ Date _____

For all changes, except beneficiary only changes, forward this form to Unum with your Lifestyle Protection Group Premium Report.