

Please retain a copy for insured.



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# REQUEST FOR CHANGE

Advance Insurance Company of Kansas is requested to make the following changes in connection with my insurance under:

Employer \_\_\_\_\_ Group number \_\_\_\_\_

Printed name of insured \_\_\_\_\_ S.S. # \_\_\_\_\_  
Last First M.I.

### Insured name change

From:	_____	_____	_____
	Last	First	M.I.
To:	_____	_____	_____
	Last	First	M.I.
Due to:	<input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Other (explain) _____		Date _____

### Beneficiary change

\*The **Primary beneficiary** receives your death benefit. If naming two or more beneficiaries, proceeds will be paid in equal shares unless stated otherwise. If listing a minor, proceeds will be paid to a conservator appointed by the court system on behalf of child. If this space is inadequate for your beneficiary(ies), attach a separate signed and dated list providing complete information.

<b>*Primary beneficiary</b>	_____	_____	_____	_____	_____	_____
	Last	First	MI	Relationship	Date of Birth	City, State
	_____	_____	_____	_____	_____	_____
	Last	First	MI	Relationship	Date of Birth	City, State
	_____	_____	_____	_____	_____	_____
	Last	First	MI	Relationship	Date of Birth	City, State

\*\*The Contingent beneficiary, below, will receive the death benefit **ONLY** if the primary beneficiary is deceased.

<b>**Contingent beneficiary</b>	_____	_____	_____	_____	_____	_____
	Last	First	MI	Relationship	Date of Birth	City, State
	_____	_____	_____	_____	_____	_____
	Last	First	MI	Relationship	Date of Birth	City, State
	_____	_____	_____	_____	_____	_____
	Last	First	MI	Relationship	Date of Birth	City, State

### Benefit change

<input type="checkbox"/> Add <input type="checkbox"/> Remove Basic Term Life and AD&D for employee – effective date _____
<input type="checkbox"/> Add dependent life benefit – effective date _____
Date spouse acquired _____ Does your spouse work for the above employer? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date first child acquired _____
<input type="checkbox"/> Remove dependent life benefit – effective date _____
<b>Note:</b> Marking this box removes dependent life coverage for all dependents, which includes spouse and all eligible children.
<input type="checkbox"/> Add <input type="checkbox"/> Remove Short Term Disability (group or voluntary) for employee – effective date _____
<input type="checkbox"/> Add <input type="checkbox"/> Remove Long Term Disability (group or voluntary) for employee – effective date _____
<input type="checkbox"/> Add <input type="checkbox"/> Remove Other (which benefit?) _____ – effective date _____
Reason for change: _____

### Class Change

From class _____ To class _____ Effective date _____
Reason for class change: _____

### Authorization — signature and date always required

I hereby apply for amendment of my enrollment as indicated on this form. I understand that if I want to add the benefit at a later date I must complete a form asking medical questions and that AICK may request other information to determine whether or not I may be insured under the group program. I understand that I will be responsible for any fees or cost including, but not limited to, obtaining medical records or an exam necessary to determine insurability and that AICK may refuse to cover me (or my dependent, if applicable). I understand that I must be actively at work before a benefit can be added. It is mutually agreed that such change shall not become effective unless and until accepted, and that this request for change will become a part of my original enrollment form and will be subject to the terms of the group policy.

\_\_\_\_\_  
Signature of Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Policyholder/Employer sign here