



# GROUP REQUEST FOR CHANGE

(VOLUNTARY TERM LIFE)

PO. Box 5044, 5420 North Service  
Rd. Burlington, Ontario L7R 4C1  
**905.319.9501**

**(PLEASE PRINT  
OR TYPE - PRESS  
PEN FIRMLY)**

- To the Employee:** Complete this form for name changes, changes in dependent coverage, changes in coverage amounts, smoker status or beneficiary changes. If you are adding dependents because of marriage or birth of a child, complete this form within 31 days after the event.
- To the Employer:** For all changes send this form to Unum with your next premium payment.

**COMPLETE NUMBERS 1 THROUGH 4 AND 10 FOR ALL CHANGES**

1. NAME OF EMPLOYER	2. POLICY NUMBER(S)	3. BILLING DIVISION
4. EMPLOYEE'S NAME (LAST, FIRST, MIDDLE INITIAL)		

**COMPLETE NUMBERS 5 AND 10 IF NAME HAS CHANGED**

5. CHANGE EMPLOYEE'S NAME	AS OF (DATE)
FROM _____ TO _____	MM   DD   YYYY

**COMPLETE NUMBERS 6 AND 10 FOR CHANGES IN DEPENDENT COVERAGE**

6.  I request that coverage be **added** under the Group Plan for:

\_\_\_\_\_ Date: (mm/dd/yyyy) \_\_\_\_\_

**Spouse**/Marriage Date: (mm/dd/yyyy) \_\_\_\_\_ Spouse's Date of Birth: (mm/dd/yyyy) \_\_\_\_\_ Life Amount \$ \_\_\_\_\_  
*Attach completed Evidence of Insurability form.*

**Child**/Birthdate: (mm/dd/yyyy) \_\_\_\_\_ Life Amount \$ \_\_\_\_\_  
*If requesting child coverage, more than 31 days after their date of eligibility, Evidence of Insurability form must be submitted with this application.*

**COMPLETE NUMBERS 7 AND 10 TO CHANGE BENEFICIARIES**

7. *To name more than one beneficiary or to name a contingent beneficiary, ask your plan administrator for assistance. This beneficiary change cancels and supersedes previous designations and may be changed upon written request.*

**BENEFICIARY DESIGNATION** *Applicable to Life or AD&D coverages*

Beneficiary's Last Name	First Name	Initial	%	Relationship
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If none of the above is living then pay \_\_\_\_\_

**FOR RESIDENTS OF QUEBEC ONLY:**  
A spousal beneficiary designation is irrevocable unless you make the designation revocable by checking here.  
REVOCABLE

**COMPLETE NUMBERS 8 AND 10 FOR SMOKER/NON-SMOKER RATE CHANGE REQUEST**

8.  Check one:

I have not smoked any cigarettes in the last 12 months.       I have begun smoking cigarettes.

**COMPLETE NUMBERS 9 AND 10 FOR DECREASING AMOUNT OR DISCONTINUING COVERAGE**

9. **Decrease** the amount or **Discontinue** coverage for: \_\_\_\_\_ Date of Decrease or Discontinuance: (mm/dd/yyyy) \_\_\_\_\_

Reason \_\_\_\_\_ Insured \_\_\_\_\_ Decrease Amount To: \_\_\_\_\_ Discontinue Coverage For: \_\_\_\_\_

\_\_\_\_\_ Life \_\_\_\_\_

\_\_\_\_\_  Self \$ \_\_\_\_\_  \_\_\_\_\_

\_\_\_\_\_  Spouse \$ \_\_\_\_\_  \_\_\_\_\_

\_\_\_\_\_  Children \$ \_\_\_\_\_  \_\_\_\_\_

10. Sign below for all changes

Employee's Signature **X** \_\_\_\_\_ Date \_\_\_\_\_ MM DD YYYY