Group Change Form

CLEAR DATA

Please retain a copy for the insured.

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

Employer: _____ AICK Group no. _____
Class

Section 1 – Insured information (always complete this section)

First Name _____ MI ____ Social Security Number ____ ____ ____

Last Name _____ Suffix ____

Section 2 – Change of name for insured

Change insured's name to:

First Name _____ MI ____

Last Name _____ Suffix ____

Reason for change:

☐ Marriage ☐ Divorce Date: ____ ____ ____

☐ Other (explain): _____

Section 3 – Class change

From Class _____ to Class _____ Effective date ____ ____ ____

Reason for change: _____

Section 4A – Change of **primary beneficiary**

Only the Insured may change the beneficiary. The change of beneficiary must be received prior to the Insured's death and will be effective as of the date it is received by AICK's home office.

This change of beneficiary will apply to all benefits with AICK. If it does not, you should indicate which benefits the change applies to:
☐ Basic Term Life and Accidental Death & Dismemberment (AD&D)
☐ Voluntary Term Life (and AD&D, if applicable)
☐ Voluntary Employee Accident/Family Accident

Primary beneficiary information (receives the benefit upon death of the insured). The proceeds will be paid in equal shares to the persons shown below unless you state otherwise. If you need more space, attach a separate sheet with complete information. You must sign and date the separate sheet.

First Name _____ MI ____ Last Name _____ Suffix ____

Relationship to Applicant _____ Date of Birth ____ or Age ____

First Name _____ MI ____ Last Name _____ Suffix ____

Relationship to Applicant _____ Date of Birth ____ or Age ____

First Name _____ MI ____ Last Name _____ Suffix ____

Relationship to Applicant _____ Date of Birth ____ or Age ____

Please continue on the next page

Section 4B – Change of contingent beneficiary (you must also complete section 4A if you fill out this section)

Contingent beneficiary information (**receives the benefit only if the primary beneficiary[ies] in section 4A is[are] deceased**). If there is more than one Contingent Beneficiary listed below, the proceeds will be paid in equal shares unless you state otherwise. If you need more space, attach a separate sheet with complete information. You must sign and date the separate sheet.

First Name _____ MI _____ Last Name _____ Suffix _____

Relationship to Applicant _____ Date of Birth _____ or Age _____

First Name _____ MI _____ Last Name _____ Suffix _____

Relationship to Applicant _____ Date of Birth _____ or Age _____

First Name _____ MI _____ Last Name _____ Suffix _____

Relationship to Applicant _____ Date of Birth _____ or Age _____

Section 5 – Benefit change

☐ **Add Dependent Life effective**____ ____ _____ Date of marriage____ ____ _____

Date first child acquired____ ____ _____

☐ **Remove a benefit effective** ____ ____ _____

- ☐ Basic Term Life and AD&D for you
- ☐ Basic Dependent Life (Note: marking this box removes dependent life coverage for all dependents; which includes your spouse and all eligible children.
- ☐ Voluntary Term Life (and AD&D, if applicable) for: ☐ you ☐ your spouse ☐ all eligible child(ren)
- ☐ Voluntary Employee Accident or Family Accident
- ☐ Short Term Disability (basic or voluntary) for you
- ☐ Long Term Disability (basic or voluntary) for you

Reason for change:

Section 6 – 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 may have to 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 1) performing all the normal duties of my job, 2) at the usual place, and 3) for the required hours each week 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.

Your signature required

Insured employee signature _____ Date signed _____

Print name _____ Social security number _____

Group signature required

Group policyholder/participating employer signature _____

Contact us at:

Advance Insurance Company of Kansas
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Topeka, KS 66629-0001

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Fax: 785-290-0727