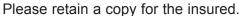
Group Change Form





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 Social Security Number Last Name Suffix Section 2 – Change of name for insured Reason for change: Change insured's name to: Date: _____ ☐ Marriage ☐ Divorce First Name ☐ Other (explain): Last Name 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 Last Name Suffix Relationship to Applicant Date of Birth First Name Last Name Suffix Relationship to Applicant Date of Birth Age MI Suffix First Name Last Name Date of Birth Relationship to Applicant Age

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
☐ Basic Dependent Life (Note: marking this box removes dependent life coverage for all dependents; which includes your spouse and all eligible children.	☐ Short Term Disability (basic or voluntary) for you ☐ Long Term Disability (basic or voluntary) for you Reason for change:
□ Voluntary Term Life (and AD&D, if applicable) for□ you □ your spouse □ all eligible child(ren)	
Section 6 – Authorization (signature and date alv	ays required)
I hereby apply for amendment of my enrollment as indicated on this form. I understand that if I want to ad the benefit at a later date I may have to complete a for 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	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
Your signature required Insured employee signature	Date signed
Print name Group signature required Group policyholder/participating emp	Social security number

Contact us at:

Advance Insurance Company of Kansas 1133 SW Topeka Blvd Topeka, KS 66629-0001 advanceinsurance.com

In Topeka: 785-273-9804 or Toll-free: 1-800-530-5989

Fax: 785-290-0727