

# EMPLOYEE CHANGE REQUEST

Name of Group (Employer) \_\_\_\_\_ Case Number \_\_\_\_\_  
Your Name (Certificate Holder) \_\_\_\_\_ Employee Number \_\_\_\_\_

## I.CHANGE OF NAME

Your Former Name \_\_\_\_\_ Your Present Name \_\_\_\_\_

Date Change Occurred \_\_\_\_\_

Reason for Change:  Marriage  Divorce  Other \_\_\_\_\_

## II.CHANGE OF DEPENDENTS INSURANCE

I wish to:  Add  Terminate insurance on the following dependent(s):

Name \_\_\_\_\_ Relation \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_ Date of Birth \_\_\_\_\_

(If additional space is needed, please use a separate sheet and attach to this Request.)

MUST SHOW DATE DEPENDENT ACQUIRED OR TERMINATED AND REASON FOR CHANGE:

Marriage Date \_\_\_\_\_  Divorce Date \_\_\_\_\_  Other Date \_\_\_\_\_

(An application must accompany this form when adding dependent(s), Health Cases only.)

## III.CHANGE OF BENEFICIARY

I hereby revoke any previous beneficiary designation and now am changing the beneficiary to :

\_\_\_\_\_  
(Show as Mary D. Doe, not Mrs. U.B. Doe) Relationship to You \_\_\_\_\_

## IV.CHANGE OF CLASS OF INSURANCE

Change from Class \_\_\_\_\_ to Class \_\_\_\_\_

Effective (mm/dd/yy) \_\_\_\_\_ New Monthly Salary \$ \_\_\_\_\_

New Job Title \_\_\_\_\_

Signed by: \_\_\_\_\_ Date Signed \_\_\_\_\_  
(Authorized Owner, Officer or Partner)

## V.YOUR SIGNATURE

**Please Note:** this change will be made effective the first of the month following receipt in our office.

I hereby request the Insurance Company to update my insurance records to show the changes set forth above and authorize deduction of any required cost from my earnings if a change of DEPENDENTS INSURANCE is made.

Your Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

**Send This Request to:**

ALLIED National  
Underwriting Department  
P. O. Box 419254  
Kansas City, MO 64141-6254  
800-825-7531 Fax: 816-221-4638