Change Request Form

Group Premium and Enrollment Services
Underwritten by: United of Omaha Life Insurance Company ● Mutual of Omaha Insurance Company

To Be Completed By Employer Or Plan Sponsor

Employer's Company Name____City___________________________State_______Zip____________
Sub-Group Name____________ ________________________Location Code____
Group I.D ______________________________ Sub-Group I.D.____

To Be Completed By Employee (Please Print)

Social Security Number ________-______-________ Name______________________________________ ___________________________ ____
Coverage(s) affected: ☐ Dental ☐ Life/AD&D ☐ Voluntary Life ☐ Long-Term Disability ☐ Short Term Disability

Employee Change(s)

	From	To	Effective Date (Mo. Day Yr.)
☐ Name[1]	____________	____________	____/____/____
☐ Salary	____________	____________	____/____/____
☐ Sub-Group	____________	____________	____/____/____
☐ Class[1]	____________	____________	____/____/____
☐ Address	____________ Address	____________ Zip Code	
	____________ City	____________ State	____/____/____
[1]Reason:	____________________		

Terminate Insurance: **Effective Date** Mo. Day Yr.
Reason (specify)_______________ ____/____/____
____

Reinstatement of Insurance: **Effective Date** Mo. Day Yr.
Date Returned to Work ____/____/____
Date Previously Canceled[2] ____/____/____

[2]Reason for Previously Cancellation: (check one)
☐ Layoff
☐ Disability
☐ Leave of Absence
☐ Other (specify) ______________________________

Dependent Event Change(s) (Both Event Reason And Date Of Event Must Be Completed)

Event Reason: ☐ Marriage ☐ Birth ☐ Adoption ☐ Step-child(ren)[3] ☐ Divorce ☐ Death
☐ Loss of Coverage (must specify reason) ____
☐ Other (must specify reason) ____

Date of Event: ________/________/________ **Amount of Life Volume for new dependent(s):** Spouse $________ Child(ren) $________
Change Life Volume: Employee from $ ________ to $ ________ ; Spouse from $________ to $________; Child(ren) from $________ to $________

ADD	DELETE	Name of Dependents	Sex	Relationship	Birthdate (Mo. Day Yr.)	Social Security No.
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					

Indicate ALL Dependent(s) Covered AFTER Change(s) above is (are) Made: (check one only)
☐ Spouse ☐ Child ☐ Children ☐ Spouse and Child(ren) ☐ No Dependent Coverage

Other Insurance
Do you or any of your dependents have coverage under **any other Dental plan** that you will retain **after** enrolling in this health plan? ☐ Yes ☐ No
If yes, please provide the following information about your/their other insurance coverage:

Primary Covered Individual	Who is covered? (i.e. employee, spouse, dependent's name)	Name of Employer offering Other Insurance	Other Insurance Company Name	Policy Number	Effective Date

INSURANCE COMPANY USE ONLY	**Instructions:** If you want to add a new dependent to this plan, you must make written request for dependent coverage by completing this Change Request Form. You must return this form to your plan administrator. To add an eligible dependent you must make your written request within 31 days (or as otherwise stated in the plan) after such dependent becomes eligible under the terms of this group plan. If your written request is made after 31 days, your eligible dependent may be considered a late enrollee and may be subject to additional conditions as stated in the plan. If the plan is contributory, this form **must** be signed and dated to authorize payroll deductions. I represent that the information I have provided in this Change Request Form is complete, true and accurate, to the best of my knowledge.
_____/_____/_____ Effective Date Of Change	**Signature of Employee ____Date ____/____/____**

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