



**GROUP INSURANCE CHANGE REQUEST**

Employer: \_\_\_\_\_

Policy Number (List all affected policy numbers): \_\_\_\_\_

Group ID: \_\_\_\_\_ Insured's Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

<b>NAME/ADDRESS CHANGE (First-MI-Last):</b>	
From:	
To:	

<b>BENEFICIARY CHANGE</b>	
Primary Beneficiary:	Relationship:
Contingent Beneficiary:	Relationship:
NOTE: Contingent Beneficiary will receive benefits only if Primary Beneficiary does not survive you. If more than one Primary or Contingent Beneficiary is wanted, please attach a separate sheet of paper.	

<b>DEPENDENTS TO BE ADDED OR REMOVED</b>						
Check One		Name (First-MI-Last)	Date of Birth (Mo. Day Yr.)	Relationship (Spouse or Child)	Date of Marriage (Mo. Day Yr.)	Late Entrant (Yes or No)
Add	Remove					
If adding dependent outside eligibility period, please explain reason:						
For foster or adopted child, show date of placement and any adoption decree.						
NOTE: If dependents are late entrants for Life coverage, each dependent will need to complete an Evidence of Insurability form and submit it to The Lincoln National Life Insurance Company for review. If dependents are late entrants for Dental coverage, and were previously covered under another plan, please complete the back of this form.						

<b>CHANGES IN COVERAGE</b>		
<b>Effective Date of Change:</b> _____	<b>Current Salary:</b> \$ _____	
<input type="checkbox"/> 1. Increase Employee coverage to \$ _____	<input type="checkbox"/> 2. Add/increase spouse coverage to \$ _____	<input type="checkbox"/> 3. Add Dependent Life Coverage \$ _____
<b>Enrollment form must be attached for items 1-3.</b> Evidence of Insurability may be required.		

<b>Effective Date of Change:</b> _____	
<input type="checkbox"/> 1. Reduce Employee coverage to \$ _____	<input type="checkbox"/> 2. Reduce spouse coverage to \$ _____

Date: _____	Insured's Signature: _____	Witness' Signature: _____
-------------	-------------------------------	------------------------------