

CHANGE REQUEST FORM
Public Employee Voluntary Life Insurance Plan #V256032

Employer: _____

Name of employee: _____

Employee's social security number: _____ - _____ - _____

Name of insured: (if other than employee) _____

Primary Beneficiary(ies)

<u>Name</u>	<u>Address</u>	<u>SSN</u>	<u>Relationship</u>	<u>%</u>

Contingent Beneficiary(ies)

<u>Name</u>	<u>Address</u>	<u>SSN</u>	<u>Relationship</u>	<u>%</u>

Cancel Coverage:

Employee Coverage _____ (please initial)
 Spouse Coverage _____ (please initial)
 Dependent Child _____ (please initial)
 AD&D Coverage _____ (please initial)

Reduce Coverage To:

Employee Coverage _____
 Coverage Amount
 Spouse Coverage _____
 Coverage Amount
 Dependent Child _____
 Coverage Amount
 AD&D Coverage _____
 Coverage Amount

Name Change: _____ **Address Change:** _____

Signature: _____

Mail to: Western Insurance Specialties
P.O. 12910
Reno, NV 89510 Questions Call 775-826-2333

Date: ____ / ____ / ____