

CHANGE REQUEST FORM

NSHE Voluntary Life Insurance Plan #08702

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: _____

Date: ____/____/____