CHANGE REQUEST FORM

Nevada System of Higher Education Voluntary Life Insurance Plan #V256033

Location & Emp. ID#: ______________________________________

Name of Employee: ______________________________________

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

Name of insured: (if other than employee) ______________________________________

Primary Beneficiary(ies)

Name	Address	SSN	Relationship	%

Contingent Beneficiary(ies)

Name	Address	SSN	Relationship	%

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:*** __________________________

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Signature:

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

Date: ____/____/_________