CHANGE REQUEST FORM

Public Employee Voluntary Life Insurance Policy

Employer: _____

Name of Employee: _____

Employee's Social Security Number: _____

Name of Insured: (if other than Employee) _____

Primary Beneficiary(ies)

Name	***Date of Birth***	***SSN***	***Relationship***	***% in whole # to equal 100%***

Contingent Beneficiary(ies)

Name	***Date of Birth***	***SSN***	***Relationship***	***% in whole # to equal 100%***

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 Desired

Spouse Coverage _____ Coverage Amount Desired

Dependent Child Coverage _____ Coverage Amount Desired

AD&D Coverage _____ Coverage Amount Desired

Name Change to: _____

Address Change: _____

_____

_____

SIGNATURE:_____ **Date:** _____

Mail to: Western Insurance Specialties
P.O. Box 12910
Reno, NV 89510: For Questions Call 775-826-2333 opt 1
Fax # 775-826-2390: Email: service@wisnv.com